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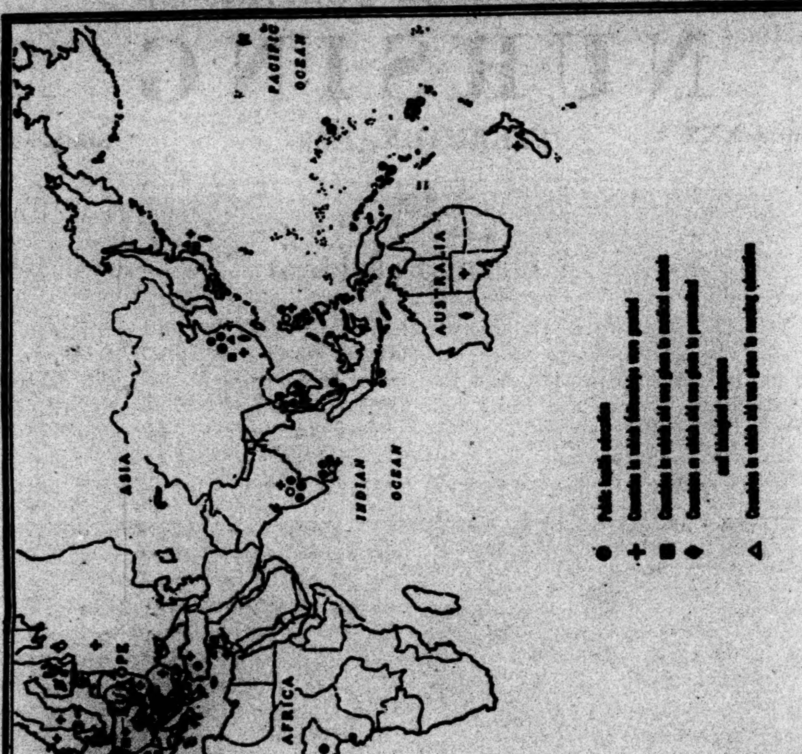
A Great President

THE true greatness of Dr. George E. Vincent was never more admirably demonstrated than in the entirely unostentatious manner of his retirement from the presidency of the Rockefeller Foundation on January first. To write even a résumé of the nursing programs aided by the Foundation during his twelve years in office would be to write whole chapters of nursing history. This is not the place for that story. All we can hope to do is to show some measure of the appreciation of the nursing profession of the contribution to its program made by a great man who, when in a strategic position, turned the searchlight of his brilliant mind on problems vital to nursing and unfailingly worked toward constructive solutions of them. His comprehension of our weaknesses as well as of our strengths made him a powerful ally—a friend whose advice was often sought and heeded quite apart from the hope of material aid. His extraordinary oratorical gifts, used always with humorous tolerance, were more than once put at our disposal. No one who heard him at the Detroit or the Atlantic City biennial will ever forget the dynamic personality, the scintillant wit, the rapier thrusts at fallacious thinking, or the recurrent plea for tolerance.

DEMONSTRATION BY NORTH AMERICAN INSTRUCTOR IN EMERGENCY COURSE FOR VISITING NURSES, DEPARTMENT OF HEALTH, BRAZIL



Map of world-wide activities of the Rockefeller Foundation in 1928.

Undoubtedly his personal beliefs were summed up in the following statement from his review of the work of the Foundation for 1924:

> To both medical education and public health work the modern trained nurse is indispensable. She is found in the wards and dispensary of the hospital; she follows discharged patients to their homes; she responds to the call of the sick poor; she reports cases of communicable diseases; she is an attendant in the health center and in the industrial clinic; she serves in the school and in the families of the pupils; she goes her rounds in city, town, and village; and of late she has made her way to isolated farmsteads in the open country. She is at the same time nurse, teacher, public official, and friend.
>
> For the successful discharge of her duties the nurse needs more than sympathy and devotion, essential as these qualities are. Apprenticeship experience alone will not suffice. There must be both education and training in hospital, dispensary and the field. Widening opportunities are making larger demands. Changes in the organization and method of nurse education are taking place, experiments are being tried, new schools are being created. Countries in which this type of training has not been developed are adopting modern ideas of teaching and practical apprenticeship.[1]

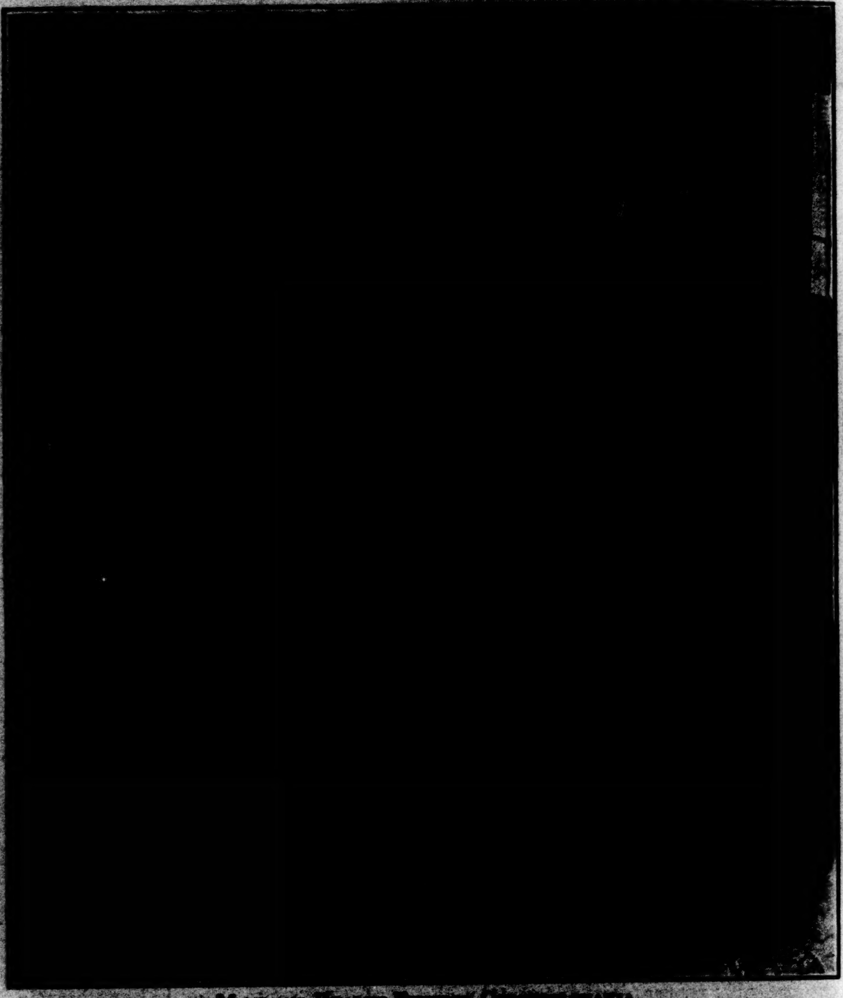
It is a far cry from hookworms to nursing education of university grade. Nevertheless, the lowly hookworm had a rather large responsibility for the inclusion of nursing education in the Rockefeller Foundation plan for promoting "the well-being of mankind throughout the world."

During 1913, shortly after its incorporation, the Rockefeller Foundation took on as one of its departments the recently reorganized International Health Board which, as the Rockefeller Sanitary Commission, had been contending with hookworm disease in the south of the United States since 1910. Now hookworm disease was at that time endangering, if not the lives, certainly the well being of some nine hundred millions of people throughout the world. Eradication of the malady was in itself a business of no small proportions, but it had a still greater significance—for without education, attempts at eradication were useless. The hookworm campaign, therefore, provided a way of educating the people in the meaning of public health and of encouraging them to take the responsibility for the prevention of other communicable diseases as well.

But, as it frequently happens, the factors which enter into health are interwoven so inextricably that it is impossible to choose one which shall have the main emphasis. And so, as these campaigns spread across the face of the world, the hookworm became only an item in a broad program of health work which included the control of other communicable diseases, visiting nursing, school nursing, infant and maternal welfare work, special clinics, and health education. The map shows the scope and span of the activities which Dr. Vincent directed for the Foundation. There is scarcely a country where it has not touched public health at some point.

It is not hard to see that nurses would be needed as auxiliaries in carrying on these operations and would be expected to do many things which in the United States, at least, fifteen years ago, hospital schools of nursing did not prepare them to do. Inevitably questions were raised as to the preparation of the nurse for public health nursing. Should her education be identical with that of the hospital nurse? What should it include and how long should it take? For answers to these questions the Rockefeller Foundation went, characteristically, to those in the nursing profession who were most familiar with the problems of nursing, with the result that, in 1919, a committee was appointed by it to conduct a study of the preparation of

[1] *The Rockefeller Foundation, A Review for 1924*, by George E. Vincent, p. 25.



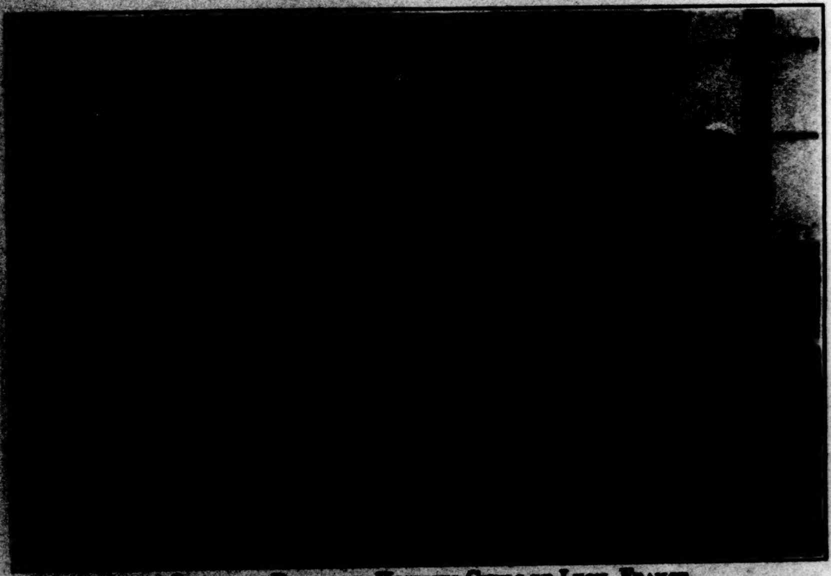
MILK AND HEALTH EXHIBIT, CZECHOSLOVAKIA

public health nurses. That no study of the preparation of public health nurses could be made without also including a study of the whole problem of nursing education and the prevention and care of illness was soon discovered by the Committee.

The findings of that Committee are well known.[8] The Yale School of Nursing was shortly after set up as a demonstration of what nursing education might accomplish. Later the

[8] "The Report of the Rockefeller Foundation on Nursing Education, A Review and Critique," Richard Olding Beard, M.D., *American Journal of Nursing*, February, March, and April, 1923.

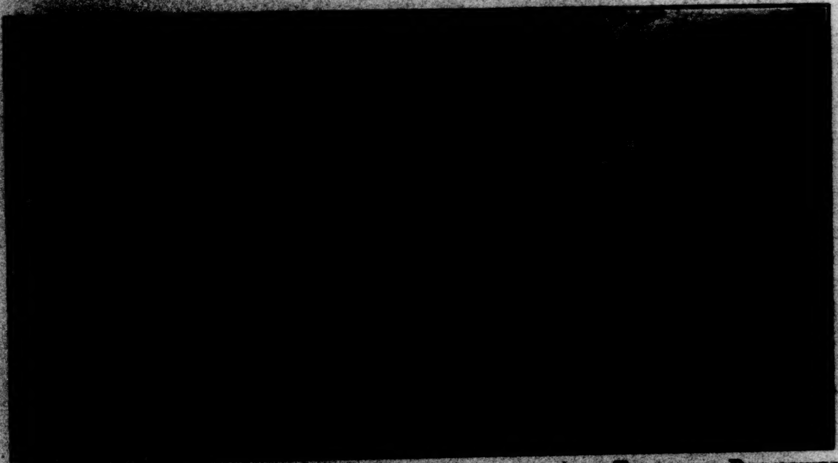
Nursing and Nursing Education in the United States. Report of the Committee on Nursing Education, The Macmillan Co., 1923.



A Lesson in Dietetics, Hospices Civils de Lyon, France

development of nursing and nursing education was made possible at Vanderbilt University through a gift of the Foundation.

In June, 1925, a gift was made, by the Foundation, jointly to the two institutions, George Peabody College for Teachers and Vanderbilt University, for the further development and extension of the Public Health Nursing



[illegible] Public Health Nurses with Alice Fitzgerald, Philippines

Practice in the Peking Union Medical College School of Nursing, Peking, China, 1925

Course. The course now offered is designated as the Peabody-Vanderbilt Course in Public Health Nursing and is conducted coöperatively by the Department of Nursing Education of Peabody College and the School of Medicine of Vanderbilt University.

Activities of the Foundation in the field of nursing education have been by no means limited to our own country. Over and over has the story been repeated. First has come a request to the Foundation for help with some public health problem; then need for nurses to help carry on these activities; then realization that schools of nursing were either non-existent or were not preparing nurses for the new conception of health; then studies of existing schools; and finally the reorganization of old schools or the establishment of new. Their story can be traced through the issues of the *Journal*, both in article and comment.

Nursing is only one of the interests of the Foundation, and the office of the president must be to view its work as a whole. Clear vision is necessary if the whole is to be made complete with all parts fitting together smoothly. The recent developments in nursing education in this and other countries have without doubt been possible because, while regarding the many parts of public health as one whole, Dr. Vincent has seen the fundamental connection between nursing education and public health.

On Rheumatic Fever[1]

IRVING R. ROTH, M.D.

THE word rheumatism has been employed for many years to designate acute and chronic joint affections. It has been used, in fact, to include a motley group of diseases characterized by aches and pains of all kinds. It has been frequently misused and has become so indefinite in its meaning as a designation for a disease entity that, today, the word stands more or less relegated to the laity and to quacks, who employ it and who seem to cherish it because of its very indefiniteness and, consequently, because of its ready applicability as a name for a large group of human ailments little understood, though much spoken of by them. The human mind, it seems, likes to classify and to "pigeon-hole." Such a tendency eliminates the necessity of thinking. It settles matters, as it were, and disposes of them. To the lay mind, the term rheumatism is a convenience. To the quack, it serves a twofold purpose. To him, also, it is a matter of convenience; but, in addition, it serves the sinister purpose of an entering wedge in his endeavors to sell remedies for something which neither he nor his lay customer understands; but he, being an enterprising fellow,—to use the modern slang,—speaks their language. With his equipment of generalities, he has access to circles where the scientific medical man hesitates to enter.

To the scientific mind, the word rheumatism has become somewhat of an annoyance. It is too indefinite; too inclusive; and, since it refers to no one thing in particular, it can serve no useful purpose as a definition. There is a tendency, therefore, to discard it. The scientific mind abhors confusion, and endeavors to evolve clear-cut clinical pictures. Accordingly, the vague term rheumatism has, in the course of years, been analyzed, and from it has been evolved a group of disease entities,—the several arthritides or the several groups of arthritis.

For instance, we now recognize two large groups of joint affections: one acute, and the other chronic. Of the chronic group, there is one designated as metabolic arthritis, caused by gout, diabetes, and, at times, by the menopause. Another group is termed chronic infectious arthritis, caused by tuberculosis, syphilis and other low-grade chronic infections. There is still another group of chronic joint involvement, caused by certain diseases of the nervous system, or by malignancy. Of the acute types, there are the several acute septic arthritides, caused by the pyogenic (pus-forming) organisms, such as the staphylococcus, streptococcus, pneumococcus and others. Finally, there is one known as acute inflammatory rheumatism.

The last mentioned nearly defines the type of disease which we intend to discuss—the type we are accustomed to see in children and young adults on the hospital wards—a disease which generally runs an acute course, lasting several weeks or months. The term acute inflammatory rheumatism is not quite satisfactory as a definition, since it implies principally an acute inflammatory joint disease. It does not define the disease properly, because this disease may affect almost any organ or set of tissues in the body. As a matter of fact, the joints are

[1] An address delivered at a meeting of the Nurses' Alumnae Association of Mt. Sinai Hospital, New York, June 6, 1929.

involved in only about sixty per cent of the cases. The more restrictive term *rheumatic fever* has been adopted to designate this disease entity; the same as typhoid fever, typhus fever, scarlet fever or any other febrile disease which may produce a widespread involvement of the body.

The designation rheumatic fever seems satisfactory because this disease like other acute, febrile diseases may, and generally does, produce an extensive involvement of the several tissues and the vital organs of the body. Clinically, for instance, we are impressed with the frequency with which this disease involves the heart, joints, lungs and even the brain. Pathological investigation, on the other hand, has disclosed that hardly any tissue within the body escapes the ravages of this disease. Focal inflammatory lesions, the most characteristic type of which is found in the heart muscle (known as the Ashoff body), may be found within the walls of the larger blood vessels and within the tendinous insertions of muscles, throughout the body. The latter are often visible clinically as the "rheumatic nodule," situated over or near the several joints—elbows, knees, ankles, wrists, and the spinous processes of the vertebrae. Pathological investigation further shows that the valvular heart lesions, which we learn to recognize at the bedside by the appearance of murmurs, constitute only a part of the actual involvement of the heart. Not only the endocardium, but every other layer of the heart wall—the myocardium and pericardium—is damaged. As a matter of fact, the myocardium (the heart muscle proper) is involved in over ninety per cent of cases of rheumatic fever. This is relatively new information, disclosed to us by the electrocardiograph. Clinically, rheumatic fever may be accompanied by an intoxication of varying degree, anywhere from a mild sense of malaise with but little or no fever, to a profound prostration with high fever, chills and profuse sweating. The causative agent of this disease has not, as yet, been finally and satisfactorily established. It is still looked upon as a disease of unknown etiology; although very convincing evidence is forthcoming, day by day, which suggests that an organism of the streptococcus group is the etiological agent. With these facts in mind, we may now proceed to define rheumatic fever.

Rheumatic fever is an acute, infectious, febrile disease, of unknown etiology, characterized clinically by fever, sweating, weakness, fleeting joint pains and a profound involvement of the heart; pathologically, it is characterized by disseminated focal inflammatory lesions throughout the body, especially involving the heart muscle, the walls of blood vessels, tendinous insertions of muscles and the serous membranes.

The course of the disease is very variable. Three general forms are recognized: (1) The monocyclic form, which consists of a single attack, mild or severe, lasting from three to six weeks; (2) the polycyclic form, which consists of recurrent attacks with intervening periods of apparent well-being; or, repeated attacks superimposed upon one another; and (3) the so-called continuous form which may go on for months in a somewhat mild or "smoldering" form—perhaps with an occasional flare. This is usually accompanied by a gradual, marked impairment of the heart. It may lead to a profound anemia.

At this point it may be of interest to compare rheumatic fever with two other diseases which have similar

manifestations from several points of view. The two other diseases are syphilis and tuberculosis. Each of the three diseases, rheumatic fever, syphilis and tuberculosis, may manifest itself in a short form—mild or severe—and may cause death during the first attack. Each may occur in recurrent stages, with intervening periods of latency; or, each may have a protracted course, leading to marked deep-seated injury to the organs which it affects. Finally, when all signs of active infection have apparently subsided, when the disease has been "arrested" or "cured," all three of these diseases tend to leave disastrous sequellae in their path. They all tend to cripple important organs. Syphilis tends to cripple the nervous system; tuberculosis, the lungs; and rheumatic fever, the heart. From the point of view of the sociologist and the economist, these diseases are of tremendous importance. Not only are their early and acute stages time-consuming during a period when the person so afflicted may be of greatest value to the community; not only do they rob the individual of the opportunity to prepare himself for his life's work; but the late manifestations of these diseases, as a consequence of their inherent chronicity, are of such a nature as to cripple their victims permanently and, often, so severely as to render them inefficient productive units in society and, at times, actual burdens to themselves, to their families, and to the community.

Of the three diseases mentioned, rheumatic fever seems to offer the greatest problem. In the case of syphilis, we know the etiological factor; we have an efficient remedy; and we have adopted adequate preventive measures. In the case of tuberculosis, the etiological agent is also known; treatment is fairly satisfactory; and definite measures have been adopted to prevent dissemination of the infection. In the case of rheumatic fever, on the other hand, we are confronted with difficulties at every step. The cause of the disease is unknown; there is no efficient remedy to cure or even arrest the disease; and we do not know how to prevent its onset or recurrence.

The picture that I have drawn of rheumatic fever, thus far, may seem gloomy indeed, and perhaps justly so. But the years of experience which have revealed rheumatic fever in all its gruesome detail have brought forth, on the other hand, some very valuable information, which enables us to recognise many of its early, mild, and hitherto unrecognised manifestations. For instance, we have learned that in the case of children the early manifestations of rheumatic fever may be very bizarre and resemble the typical textbook forms, seen in adults, in a very small way, or not at all. In the case of children, such apparently innocent conditions as mild joint or muscle pain, growing pains, wry neck, nose bleeds, skin rashes, chorea, frequent tonsillitis or frequent sore throats without tonsillitis, may be the forerunners of a severe attack of an acute rheumatic fever. On the other hand, any one of these or any combination of these apparently mild conditions may be the only outward manifestations of rheumatic fever, while the heart itself may be undergoing progressive, serious damage. This information regarding the bizarre nature and protean manifestations of rheumatic fever in childhood is of a tremendous value to the clinician. It enables him to recognise the disease in its incipiency and to institute therapeutic measures before the patient becomes overwhelmed by the infection. Our therapeutic measures,

to be sure, are very limited. Nevertheless, even if we assume, in all modesty, that we have none at all and that the cure, if any, is nature's own work, early recognition of the disease and early institution of rest, proper diet, nursing care, and medication to relieve symptoms, must obviously be to the best interest of the patient. Such a timely routine undoubtedly helps to direct all of the patient's latent energy toward fighting the infectious agent, whatever its nature may be. This phase of our knowledge regarding the nature of rheumatic fever in children, and its intelligent application, may well be termed the proverbial silver lining to that cloud of gloom which I may have caused to appear in your minds while I was referring to the disastrous cardiac sequellae of rheumatic fever and the enormous difficulties encountered in dealing with the fully developed disease.

The incidence of rheumatic fever makes another very interesting study. Does every one of you know that rheumatic fever is essentially a disease of childhood and adolescence? Do you know that there are several cases of rheumatic fever on record in children under two years of age, and that the height of the age incidence is between five and seven years? The incidence falls sharply after puberty and is rather low during adolescence. The disease is relatively rare, as a first attack, in adult life—after thirty years of age. Adults who suffer from attacks of rheumatic fever have probably had it at an earlier age.

Girls seem more subject to rheumatic infections than boys. The proportion is almost two to one.

In certain families there seems to be a distinct predisposition to this type of infection. As far back as thirty years ago, a prominent English physician reported that seventy per cent of his private patients with rheumatic fever had had more than one case in the same family. About eight years ago, a study at one of the New York hospitals revealed the interesting fact that the frequency of familial incidence in rheumatic fever is as great as the familial incidence in tuberculosis.

Some studies even suggest a direct family infection—a house infection or group infection. In 1920 there had been recorded five distinct epidemics of rheumatic fever among Italian troops, suggesting strongly that a direct infection from one person to another may take place.

A great deal has been written on the geographical distribution of rheumatic fever. It seems that the disease is distinctly one of the temperate zone. It is very common in England and along the North American coast of our own country. The South and the Middle West are almost free from it. Recently a visitor from New Orleans, a physician of extensive experience, and a teacher in a medical school, told me the interesting fact that, at his clinic, rheumatic fever or rheumatic heart disease is demonstrated only as one of the rare diseases, and that he has found it difficult to secure a sufficient number of cases to teach his students. In Arizona the disease is almost unknown. In cities like New York, where the disease is endemic, the distribution of rheumatic fever seems to be along the water fronts. There is a tendency to ascribe it to dampness and humidity. This seems far-fetched. Humidity is certainly far greater in the tropics than in the temperate zone, yet rheumatic fever is almost unknown in the tropics. It is perhaps safer to assume that rheumatic fever, in a locality where it is endemic, is more apt to be prevalent where there is overcrowding, poverty

and filth. These conditions prevail at the water fronts of our large cities. Hence the prevalence of rheumatic fever in such localities. Rheumatic fever, therefore, may be justly termed a disease, not of dampness and humidity, but of overcrowding, poverty and filth.

As to symptoms: I have already pointed out that, in children, rheumatic fever may present few or no symptoms and that severe heart damage may go on nevertheless. Joint pains are most common in adults. Many children never complain of joint pains. The height of the temperature is no indication of the severity of the disease. A protracted low-grade fever is often more dangerous than a short attack of the disease with high fever.

As to physical signs: swollen, painful joints are usually met with in adults. Typical joint effusion is not common in children. The joint involvement in rheumatic fever is quite characteristic in that it is of a fleeting nature. Joints are involved successively, the affection remaining for three to six days in each of the involved joints. Signs of cardiac damage are more common in children.

As to the course of the disease: adults usually have single attacks of relatively short duration. In children it is the recurrent or the protracted form that is most common. In fact, it is hard to tell at times when the disease is over in children. It frequently lasts for many months. Recently, there has been reported in New York, the case of a child in whom evidences of recurrent rheumatic fever have been observed for a period of twenty-two months.

How do we treat a case of rheumatic fever? Rules cannot be laid down dogmatically. Every case is an individual problem. One may postulate in a general way, however, and say that every case requires rest, nursing care, dietetic, mechanical and medicinal measures.

In an acute case, rest and nursing care are of the utmost importance in order to preserve the patient's strength, for he may have a long fight on hand. The diet must be liberal. Do not "starve the fever." In fact, nowadays, the better informed physician prescribes an abundance of high caloric diet, very much as in typhoid fever. The mechanical measures referred to imply proper posture (one that gives most comfort to the patient) and appropriate protection of the inflamed joints—bandages, splints and massage. Of the medicinal agents, we rely upon sedatives and the salicylates. The salicylates are not a specific remedy. They are of definite help in allaying pain and in helping to absorb effusions from the joints.

During convalescence, the patients need the same tender care as during the height of the disease. Convalescence must be prolonged. Nutrition must be kept up. The temperature must be watched in order that a recurrence, a flare up of the disease, may be detected in time. It seems that the sanatorial methods employed in the care of the tuberculous might also serve in the case of those convalescing from rheumatic fever.

As to prevention: the most important single measure of prevention would seem to be that every child living in cities where rheumatic fever is endemic, when seemingly ill without a definite diagnosis, should be accused of having rheumatic fever and treated as such until proven otherwise. This is suggested with the hope that timely attention given to a mild manifestation of the disease might forestall the onset of a severe attack of rheumatic fever.

State Standards[1]

The Need for Greater Uniformity in Requirements

ETHEL M. SMITH, R.N.

WHEN Miss Van De Vrede sent me the title of the subject she wished me to present at this time, it seemed to me there was much that could be said, since it is a matter constantly before the secretaries of state boards of examiners. I found, however, in whatever direction I took a step, some obstacle appeared, until finally, from one source only, there seemed to emanate a faint ray of light that some day might lead to a solution.

Were it possible for all boards of examiners simply to endorse the examination given in the applicant's home state, requiring, in addition, merely educational, professional and character credentials, it would be a simple thing, but to do this, the type of examinations put up would have to be regulated in some way, and this would be most difficult, if not impossible, while such differences exist in the personnel of the boards of examiners. I have recently seen the examination put up in one state, where twenty questions only were submitted. These covered all subjects and constituted the whole examination. In Virginia (and I think many states have similar rulings), we give 100 questions under ten different headings—10 questions each—and, in addition, give a practical examination to each applicant. There could be nothing fair about requiring this of our own students and accepting, as equivalent, the examination mentioned.

It would seem impossible, too, to attain any real uniformity in our state laws. Any such attempt seems useless while some states regard as essential, points that are not even taken into consideration by others. We all avoid legislation when possible. Practically all states have had vital points in their laws jeopardized and the accomplishment of years threatened through the attitude of some unsympathetic legislator who probably has not made any effort to become really posted about the question. One needs only to study the substance of the laws of the different states having legislation in regard to nursing, to realize how seldom such acts have been passed without the introduction of something we know could never have been desired by the nursing profession. Sometimes the principle involved seems unimportant, but again embarrassments have arisen from various insertions and curtailments.

The *Digest of Laws Requiring Registration for Nurses* issued by the American Nurses' Association, is most illuminating in showing up all discrepancies and differences, and one needs only to give it consideration to see how difficult it would be to establish reciprocity on the basis of uniformity on even the vital points. Honorable discharge from the Army or Navy permits registration without examination in some few states. Several states reciprocate *if* the state seeking reciprocity will grant it in return; a few stipulate that the requirements of the state where applicant is already registered shall equal the requirements *at that time* of the state in which she desires to register. The length of course varies in the different states from two to

[1] Read at the meeting of the Southern Division of the A. N. A., Birmingham, Alabama, October, 1929.

three years; the hospital requirements vary from twenty to seventy beds, and daily average from twelve to fifty patients. Many states seem satisfied with requiring certain bed capacity without regard to average number occupied; some few specify the variety of experience to be offered; one merely stipulates "hospital must be controlled by physicians in good standing."[3] The course in theory, where mentioned at all, varies from fifty hours of didactic instruction each year, to the full number of hours outlined in the curriculum put out by the National League of Nursing Education; the age of acceptance ranges from eighteen to twenty-two; the registration fees from $2 to $25; the preliminary education varies from common school education to completion of high school. Practically all states in their reciprocity clauses state that "Equivalent educational standards are required," but there comes in the problem of having these "educational standards" evaluated. It appears to be quite within the rights of each state to evaluate the education offered in its own schools. There is nothing in the Constitution of the United States covering the question of control in matters of education—therefore each state has gone its own way in this matter without interference. So it may be seen how futile would be any attempt to exact uniformity even in preliminary education. In the Articles of Incorporation of our American Nurses' Association, it is agreed that its by-laws and regulations shall not be inconsistent with the laws of the United States, *or any state thereof.*

Yet, in the face of all these wide differences in standards and requirements, practically all states show they recognize the need for reciprocity by having a clause embodied in their laws covering it. How, then, can we arrive at some proper basis for the establishment of the reciprocity desired?

As doubtless all here know, a National Board of Medical Examiners was organized in 1915, and began operation the next year. Its purpose was to establish a standard qualifying examination of such character that the certificate awarded successful candidates could be safely accepted by all state boards of medical licensure as an adequate qualification for the practice of medicine. It is now recognized quite generally in the United States, and also in Great Britain and other countries. The United States Army and United States Public Health Service recognize it for admission to their medical corps. Though the diplomates of this National Medical Board are excused from examination in practically all states and territories, many of the individual states have their own additional rulings in regard to different points, and applicants are required to meet these, in addition to holding the national certificate. For instance: Maryland and North Carolina require a personal interview; in Illinois, Maine, and Wyoming, an oral examination is given; in other states a certain amount of practice is required; and several others reserve the privilege of reviewing the candidate's credentials, etc., etc. There are a few states that, as yet, have not recognized this certificate, probably due to certain technicalities in the laws of these individual states. The requirements which must be met by an applicant for this examination cover full high school course and two years of college work, embracing certain courses, graduation from a medical school rated in "Class A" by the American Medical

[3] It is unfortunate that it is possible, in some states, for schools to exist in hospitals disapproved by the College of Surgeons.—EDITOR.

Association, and an interneship in an acceptable hospital.

The possibility of national reciprocity for nurses, based on federal examination, has been discussed at intervals for several years and points for and against it have been brought out.

Considering the wide variation in our laws and rulings and the difficulties of adjustment mentioned before, it almost seems impossible ever to accomplish a national reciprocity. However, to some of us, the fact that our schools in all states have recently *voluntarily* supplied information to a grading committee, asking that their schools be rated and that they be shown where they stand, sounds a note of hope. It certainly indicates an acceptance of this outside committee, and suggests a willingness on the part of the schools to accept its decision and to work toward higher standards. A universal elevation of standards may result. This, I am sure, is the hope of the A. N. A., of the Committee, and also of some of the rest of us.

When the piece of work now being done by the Grading Committee has been completed and all participating schools graded, if the information could advisedly be made public, it would seem possible that a graduate from any school which obtained a high rating, who was registered in her own state, might be considered eligible for examination by a national board and, upon obtaining a national certificate, be granted registration without examination in states where the individual requirements were also met by her. This would necessitate, of course, the formation of a National Board of Examiners whose work, in addition to the examinations, would have to include seeing that those schools graded high were kept up to the standard, and that others desiring recognition should raise their standards to meet requirements.

It seems the question for us to consider at this time is how can we, of the Southern States, help towards the simplification of this problem. Leaving the question of the state laws for the present, would it not be possible to get our board requirements on a more uniform basis, striking out the non-essentials and emphasizing the essentials? We could, at least, see that the same language was spoken in our states, so as to make classification easier. It would seem a fitting time to agree upon this—possibly forming a committee for the study of our board rulings and requirements, our forms, etc., and then later see if we can make adjustments. For the present, perhaps, this is all we can do.

Meantime, while we are waiting for the work of the Grading Committee to be completed, it would appear to some of us that the most satisfactory method of granting reciprocity is not by means of a reciprocal agreement between states, but by individual consideration of each application for registration without examination, based upon the record of preliminary education, the moral character of applicant, the standing of her training school, and her record of professional work, both practical and theoretical. This method is now used by several states, as you all know. I realize this does not make it possible for a nurse to establish herself in a different state without some slight delay, but for the present it seems the best that can be done. It does give the individual a chance for recognition that she would wait long to obtain if she had to depend upon the attainment of uniformity in state laws.

Nursing in Jugoslavia

Glimpses of the Preparation and Work of Health Nurses in Jugoslavia

RUTH INGRAM, R.N.

ABOUT ten years ago, a physician of Jugoslavia became convinced that the mortality rate of his country was far too high, and set about the task of lowering it. As a result of Dr. Stampar's labors, Jugoslavia has as broad and inspiring a health program today as any country in the world. Nine splendidly equipped institutes of hygiene are scattered over the land, and out from these radiate some forty "health homes" or centers in cities, and about one hundred and twenty-five health stations in rural districts. As peasants constitute nearly 80 per cent of the Jugoslavian population, the rural health stations form a most important factor in Dr. Stampar's program, and the nurse is a very essential factor in the health station.

This nurse lives in the station; she organizes and assists in the various clinics which are conducted in the station; she prepares and distributes infant feedings; she makes instructive visits to the homes of her district; and she usually becomes the friend and advisor of the whole community. Except for the doctor's brief visits two or three times weekly to conduct clinics, she reigns as supreme health authority in her locality. With little supervision, often far from the Institute, what is such a young nurse able to accomplish? In village after village, the mortality rate has dropped 50 per cent after the station has been opened two years. One village, which formerly reported that 70 per cent of its deaths were infants, now reports 70 per cent are old folk. It is very pleasant indeed to hear the health authorities

BELGRADE STUDENT BODY WITH MISS HELLICH

credit most of these marvelous changes in vital statistics to the work of the nurses.

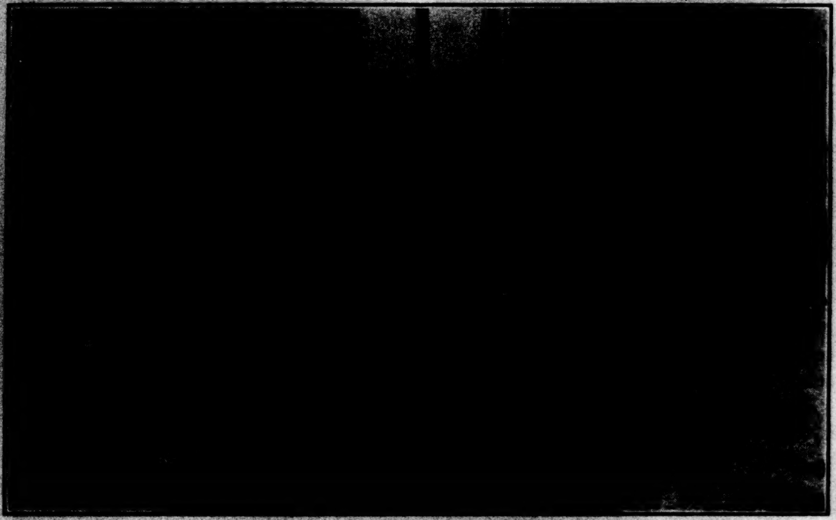
One is naturally eager to find out how these nurses are prepared for such work. There are two schools of nursing in Jugoslavia, and a third which trains in the care of children only. Dr. Stampar saw clearly from the beginning that he must have health nurses to carry out his program, so all three schools have stressed preventive nursing. Nearly all their graduates have gone into the public health service, but even so there are not enough nurses to supply the growing demands of the work.

The School of Nursing at [illegible]

The nursing schools are established apart from hospitals, as is the custom in Europe. This frees the directors of the schools from the anxiety which haunts the heads of most nursing schools in this country, namely, how to give the student a well rounded clinical experience and at the same time provide adequate nursing care for the hospital patients. But on the other hand they are faced by the very difficult problem of securing suitable experience in the care of sick patients for their students. Civilian and religious hospitals have for centuries been nursed by the Sisters of religious orders. These women spend their whole lives in most devoted, though technically not highly skilled, care of their patients. Nursing to them is not merely an occupation; it is their pleasure, their recreation, their touch with the outside world, their emotional outlet, their very life. Long hours of drudgery do not quench, nor even dim, the flame of their self-sacrificing service for the sick poor. Natural enough then, to understand their hesitation and dismay when asked to give over the nursing on certain wards as clinical experience for student nurses. Leave their beloved patients to the care of young women who no sooner learn how to give bedside care and treatments deftly than they are replaced by bungling beginners, and who are more interested in the physical condition than the spiritual welfare of their patients? It speaks well for the broad-mindedness and sincerity of both groups that not only have the Sisters given over to the students the nursing on the desired wards, and shared the work with them on others, but have even sent members of the Sisterhood to the schools to take the nursing course. This will result in a

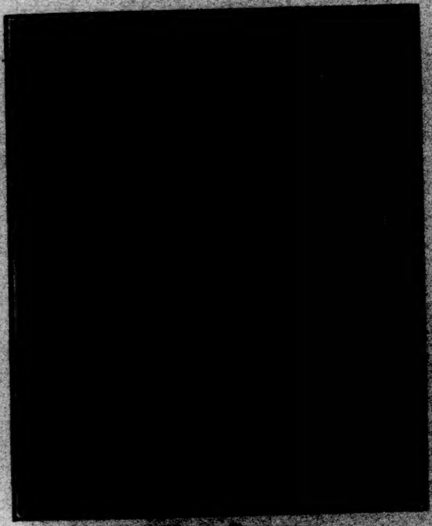
gradual raising of institutional nursing standards throughout the country.

The Red Cross School in Belgrade is housed in an imposing building, whereas the School for Public Health Nurses in Zagreb occupies some old and inadequate barrack buildings. But both schools are fortunate in having good classrooms and well equipped dietetic and nursing laboratories. The students live in the schools throughout their course, and go daily to various hopsitals and dispensaries for clinical practice. Their work is supervised by the principals of the two schools and their assistants, but this is difficult as some of the hospitals and clinics lie far from the schools. Take, for example, the Military Hospital in Belgrade. It was the first hospital to open its doors to student nurses. The military doctors and surgeons are very friendly so that there is good discipline and a pleasant atmosphere on the wards. But, unfortunately, the hospital is across the street, and the Civil Hospital, where students also go, is about 20 minutes away, from the school, so that Miss Hellich, the principal, and her assistants, cannot give adequate supervision. Nor can the patients be properly looked after by the few available nurses. Linen and other equipment are very scarce; utility rooms and diet kitchens are inadequate or non-existent. The problem is financial. With better nursing facilities and a larger staff of nurses and supervisors, plus the cordial good will which already exists, the students could get excellent medical and surgical experience in that large hospital.



Belgrade Students at Work

In some of the other hospitals the equipment is much better and more supervision is possible. Frequently a senior student is in charge of a ward under the direction of a supervisor. In one hospital, student nurses are doing all the bedside nursing on certain wards by day, and nuns are responsible for ward housekeeping and



A W[illegible] C[illegible]

the care of these same patients by night. The neat and attractive appearance of the ward, and the contented patients prove that this unusual division of work is successful.

Both schools find it much easier to arrange for experience in preventive nursing. Good school polyclinics with all facilities from shower baths to dining rooms have been established. Pupils are also sent for stated periods to tuberculosis, prenatal, well-baby, venereal-disease, and alcoholic clinics, where their work usually includes instructive visits to the homes of patients.

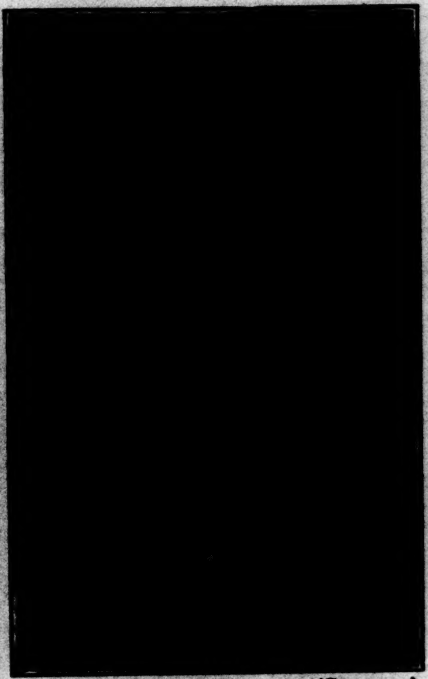
The theoretical work given by these two schools compares quite favorably with the courses outlined by the Curriculum of our National League of Nursing Education. The Zagreb School offers about 570 hours of lecture and laboratory work in the basic subjects, whereas our Curriculum calls for 825 hours. They devote less time to the foundation sciences and to the theory and practice of nursing than do we, but give 100 hours to hygiene, sanitation problems, public health propaganda, etc. Most of the lectures are given by doctors, who apparently enjoy teaching the nurses. The course has covered two years, but has now been lengthened to three because this theoretical program kept the students from getting sufficient practical experience during the two-year period.

Unfortunately, the schools can accommodate only about half of the eligible young women who apply for admission. The Zagreb School allows a few whose homes are in the city to enroll as day pupils. All the students have had at least four years of "secondary" school. This is not, however, comparable with our high school; it means at most eight or nine years of schooling. Some of the students at Zagreb have their "matura" which is more than equivalent to our high school diploma. Many come from better-class homes and the rest are of sturdy peasant stock. Both Miss Hellich at Belgrade and Dr. Simec at Zagreb have reason to be proud of their intelligent, fine-looking groups of students.

Miss Hellich received her training in Vienna, and has been in charge of the Belgrade School for several years. Dr. Simec was trained as a bacteriologist, and was requested to take charge of the school at Zagreb after two other women had failed, one on account of ill health, the other from lack of training and experience. Year by year her interest in nursing has grown until she, herself, says that she is now 90 per cent nurse. Strange as it may seem to American nurses to find a woman physician at the head of a nursing school, anyone who will delve into her curriculum and listen to her plans for the future will realize that Dr. Simec is ably and devotedly doing a difficult

piece of work for which the fine young nurses of Jugoslavia have not, at present, the needful maturity and experience. Indeed, one is deeply impressed by the quiet courage and steadfast purpose of both women who have overcome many obstacles and are using every opportunity to improve their schools.

Many interesting stories could be told of the work which is being done by the graduates of these schools. Perhaps the most unique original contribution is made by Sister Anne Papaliopulus. Several years ago she saw that the peasant women do not as a rule understand how to cook and serve food properly. They use very few green vegetables, and do not give sufficient milk even to the babies. She persuaded a group of women in a village to attend a cooking class. She found a place to hold the class and they provided the materials. The class was such a success that Sister Anne's fame as a cooking teacher has spread over the whole land, and from all directions, nowadays, invitations to conduct cooking classes come pouring in. We visited her as she was giving her course last winter in the distant village of Plesma. As our sleigh drew up before the schoolhouse on a frosty afternoon, Sister Anne bounded out to welcome us. She glows with vitality and energy. She had started a new class two days previously, and the fact that she sat down with thirty guests that evening to a delicious dinner cooked and served by those new pupils proves that she is an able teacher. After the tables had been cleared, fiddlers struck up an old Slavic dance tune. One by one, the girls and women formed a circle, all dressed in their lovely peasant costume of white homespun richly embroidered with bright-colored silk or wool threads and with tightly fitted bodice and long, voluminous skirts. They chanted in high, sweet voices as they moved through the stately measures of the picturesque old folk dance. At last the men and boys who had been standing around the sides of the room joined the bright circle and the gaiety increased. They danced old dances and new dances and finally turned to rollicking games which they played with the most spontaneous enjoyment. Everyone had such a good time that the party did not break up until four o'clock in the morning! Sister Anne had shown the village that a party without alcoholic stimulants could be a success.



A WATER CARRIER IN DALMATIA (GOATSKIN)

Sister Anne is as popular as she is practical. The men adore her because after her visits they get better meals at less cost; and the women love

HOME OF HEALTH (HEALTH CENTER) TRAINING CENTER FOR PUPILS—MRACLIN

her for the sound, shrewd help she gives them in their everyday tasks. Each community offers different problems. In one village, she found the women did all their cooking stooping over low braziers set on the floor, and when she showed them how they might place the braziers on brick platforms and relieve their aching backs they blessed her. Few communities are quite so primitive as that one, but she can usually teach labor-saving methods and devices. Her course lasts for three weeks. She tries to follow it up after a year with a ten-day course in canning and preserving, and thus check up on the results of her earlier teaching. She has been pleased to find that, as a rule, her pupils are using the information she has given them. Perhaps the men insist that their wives live up to Sister Anne's standards of cooking! At any rate, she has the satisfaction of being able to see that she is doing a splendid service to a great number of people and she thoroughly enjoys her work. She likes to travel about, meet new people, face new problems, and seems quite oblivious to the many discomforts she has to endure.

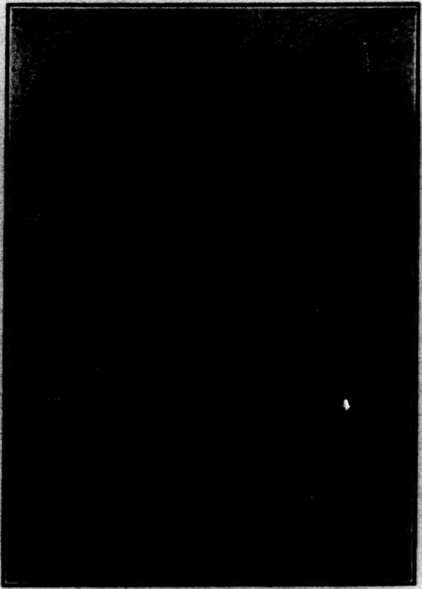
She has gradually become the vanguard for the health authorities. She is frequently invited to hold classes in districts where no health work has been started. If she finds interest in health propaganda, an officer from the Institute of Hygiene goes out to the village to determine whether regular work shall be started there. At Plesma, where we visited her, the people were begging for a health station. Dr. Rasuhin, the Professor of Public Health, took the long trip down from Zagreb to look over the situation and to find out how much financial support the village was prepared to give. It is customary for the local people to build the station and supply the current expenses while the Department of Health provides the personnel. Dr. Rasuhin took with him a movie machine and several films and began their health education with a series of lectures on tuberculosis, infant care, etc. A good many of the peasants had never seen a movie before, and to everyone the films were apparently a treat, for his audiences stood spellbound through two-hour lectures.

Miss Holjevac is stationed at Mraclin, once a wretched hamlet, but now the thriving model village of Jugoslavia. The villagers, in coöperation with the Institute of Hygiene, have filled in malarial swamps; constructed manure pits, sidewalks, a drainage system; installed sanitary pumps in place of the picturesque but deadly open well, and have built themselves a health and community centre. Students from the Zagreb School of Nursing are sent down, two at a time, to this admirable rural training field. Miss Holjevac has twelve villages in her district. She has organized a committee of peasant women through whom she works. One woman in each village acts as her agent in reporting cases and gathering information. Visits to peasant homes show that her constituency lies in the hollow of her hand. One morning she was out at 5.30 assisting the veterinary to

immunise chickens against cholera. On a Sunday afternoon, a woman came to ask if she had time to show her how to prepare sweet peppers. She spent the rest of that day peeling peppers and canning them. By methods such as these she and the other nurses all over the country "approach" the families in their districts to gain confidence and respect for their health work.

The results justify the means. In a country where fathers, sons, and grandsons with their respective wives and families occupy the same house, and share a common bedroom, and where each peasant woman still weaves beautiful linen and silk fabrics on her own loom, the health authorities have skillfully adapted their propaganda to the interests and needs of the people. A good example of this is the novel experiment in health education which was started in Zagreb last winter. A Peasants' Institute was opened. During five cold, snowy months when there was little to be done on the farms, a group of fifty young peasants were taught improved methods of agriculture, scientific care of stock, how to plan and build comfortable houses, and many other things. Hygiene and health were the underlying "motifs" of the whole course. They lived together in a dormitory, and for the first time in their lives, slept with open windows in cold weather; they sat down to appetizing meals prepared under the direction of a young nurse recently returned from America, and were astonished to learn that the materials and cost were practically the same as for their less attractive meals at home. Was the Institute a success? One had only to look at the students' faces shining with enthusiasm and joy to read the answer.

But it is not men only who benefit from the Peasants' Institute. As soon as the men's class had closed, a two-months' course for women would open. Household management, cooking, and home nursing were to be part of the proposed curriculum, and most of the teaching was to be done by nurses. During the summer months when the peasants are busy on their farms, the Institute plans to offer a course in hygiene to priests and school teachers.



A PEASANT'S HOME IN MRACLIN
Note the Protected Well

The people of Jugoslavia are beginning to realize that health pays. They have great confidence in Dr. Stampar's ability and honesty. In spite of many obstacles, he is able to get the money necessary to make his organization bigger and more effective each year. Since nurses are a vital part of the health program, we may expect some interesting developments in nursing education to come from the Balkans during the next few years.

Side Lights on Over-Weight

EOLINE CHURCH DuBOIS, M.D.

OVER-WEIGHT today is a real problem and is no longer to be endured with resignation. Although the stock remarks, "I suppose it is my nature to be fat," and "My husband says he prefers me this way, rather than to have me starve," may be true, and may satisfy many women, nevertheless the truth which must be faced is that while fat people may be merry, they are not long-lived. This has been brought home to us not only through the medium of our own observations, but from a far more compelling source, the statistics of the insurance companies.

It is a trite saying that figures often lie, but insurance figures come as near to being absolute truth, as can be found in a world of inaccuracies. These figures tell us that over-weight people must be classed among the more hazardous risks and, like any other abnormality, as for instance a heart murmur, must be paid for accordingly. In other words the insurance companies will accept over-weight risks, but at an excess premium. All of which means that fat produces a great deal more than ordinary discomfort, personal humiliation, and added expense for one's wardrobe. In its train follow diabetes, arteriosclerosis, heart disease, and a general interference with the normal cellular activity of the body.

Aside from the actual diseases that may follow in the train of this condition, isn't it true that it slows down any effort, mental or physical? Isn't the traditional good nature an acquired unwillingness to assert ourselves even to get mad?

The question arises as to why some people are fat while others, living under apparently the same conditions, are not. Heredity unquestionably plays some part. There are generations of fat people just as there are of thin ones. Whether obesity depends on some inherited deficiency, or has been acquired through one's environment, requires investigation of each individual case.

The writer was lunching recently with a group of women, and as the dessert was being passed, the subject of diet came up as it inevitably does, and attention was directed to an abnormally thin woman, whose well filled plate bespoke a good appetite, and who was unquestionably enjoying her food. As Postum says, "There's a reason," and so it proved in this case, for on closer observation, an enlargement at the root of her neck became quite visible, and explained her extreme thinness despite her good appetite.

If we could have done a basal metabolism test, that is, measured the woman's oxygen requirements for twenty-four hours we should have found them far above normal. For in the presence of an over-active thyroid gland, which this obviously was, the engine of the body is kept running at top speed, and therefore requires more than the normal amount of fuel to keep it going. Even in a state of rest the motor is accelerated. Such excessive demands allow no chance to store up fat. It doesn't seem to make any difference how much these people eat; they can never satisfy the body's insistent demands for fuel.

On the other hand, just as the metabolism is high in these cases of over-activity of the thyroid, it is correspondingly low in the opposite condition, subnormal activity of the

thyroid, which is characterised by marked lethargy and increased weight. Extreme cases of both these conditions present no difficulties of diagnosis, but the border-line cases, that are in their incipiency, can be determined only by the metabolism test. Unquestionably there are many heavy eaters of very slim build whose energy requirements, as shown by the amount of food consumed, would predict an abnormally high basal metabolism.

Diabetes is also characterised by a ravenous appetite associated with a marked loss of weight. But this loss is not due to any over-activity of the pancreatic gland (which is the gland associated with diabetes) but to a decreased activity which results in the accumulation of sugar in the blood. However, these diseases have this in common, that they are both associated with the chain of glands which have internal secretions and which we call endocrines.

The question therefore very naturally arises, if emaciation be due to some endocrine disturbance, why may not obesity be also related to this chain of glands? If obesity is a question of metabolism to which the endocrines hold the key, why not stimulate these endocrines to increased activity and make ourselves slim and beautiful without the necessity of dreary dieting?

We may open the argument by admitting immediately that obesity is certainly a question of metabolism and that the endocrines have a marked influence over the vitality and efficiency of the tissues. It is quite possible that the variations which perfectly normal people show in their reactions to different stimuli as work, food, and emotions of any kind are due to their endocrines. However, in analyses of two hundred cases of obesity, the writer found but two in which the metabolism under conditions of rest was below normal genuine cases of hypothyroidism. And other investigators support the conclusion that the vast majority of obese persons show no glandular deficiency under test conditions. If therefore we insist that the metabolism is at fault, it must be that the deficiency arises after the load of the day's work is put on. Very much as an automobile engine goes along merrily in the garage, but once on the road develops a skip. It is under the conditions of load that the similarity between normal people vanishes and differences appear. In other words, metabolism appears automatically to adapt itself to requirements in some cases, in others it fails, which goes to prove that in order to treat obesity successfully, it must be treated from the point of view of the individual and not of the disease.

We must bear in mind that metabolism fails gradually with advancing years, due to the fact that the endocrines become less active as growth and reproduction demands cease. It is higher in cold weather and lower in summer which gives us a reason why summer food should be lessened in amount. Due to the over-heating of our American homes, it is a question if we are not nearly always running on summer metabolism, so to speak. It is raised by exercise and lowered by rest. Some foods raise the metabolism more than others, and it is raised by certain extracts of the endocrine glands, notably thyroid.

These form our cues for the satisfactory reduction of overweight. Cut down our intake of food to equal the requirements suited to our years, our occupation, our height and the season of the year. Step up our engine by increasing our bodily activities, instead of encouraging the natural physical deterioration of middle

life by surrendering to the seductions of good food and easy living. The use of gland extracts for stimulating metabolism has a definite place under certain conditions and under intelligent supervision *only*. Such increased metabolism is gained by increasing the heart's action, thus sending the blood at a more rapid rate through the blood vessels and returning it to the lungs for a fresh supply of oxygen. It is pretty dangerous to over-work a heart enveloped in fat, and a circulatory system that has a certain amount of sclerosis. There are however occasions when endocrine therapy is most valuable.

It is amazing how plausible the widely advertised "obesity cures" read to thousands of women otherwise intelligent. The claims of the quack vendors are so impudent that it is extraordinary how successful they are in deluding the public. The breads at fifty cents a loaf, containing more calories than the ordinary graham bread at fifteen cents; the salts for the bath, the only virtue of which is the water they are dissolved in; the tablets which knock out the digestion, or act as cathartics, or contain dangerous drugs; all these and others too numerous to mention base their whole efficacy on a restricted diet and exercise, despite the claims that no exercising nor dieting are necessary!

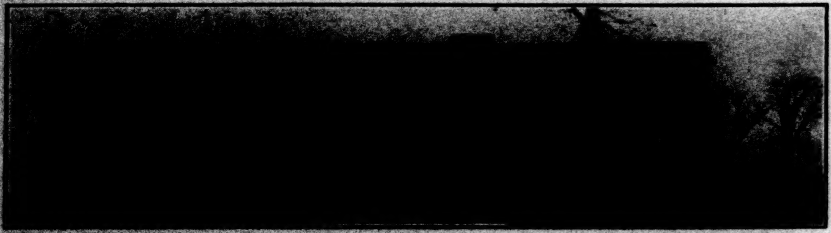
The cost of these various preparations varies, but it is safe to assume that for every dollar spent in their purchase, not more than a nickel has gone into their preparation. The royal road to slimness was never found through the use of patent medicines, nor the purchase of any special brand of cigarettes.

Frequently our attention is drawn to garish suggestions for rapid reducing diets—the "eighteen-day diet," the "one-week diet," etc. All of them are low in calories and restricted in variety. This is quite in accordance with the speed of the times. The moment a woman realizes she is too fat, she wishes to reduce. She wants to divest herself in one week of the slow accumulation of years. There are certain disadvantages in such rapid reduction attempts. The results are very debilitating, the loose folds of flesh are very unbecoming, and there is the further disadvantage of the treatment being too radical for lasting benefit. It is like doing an emergency operation where no emergency exists, and where a later operation will be necessary.

The more closely one approximates the normal diet, the easier it will be to adhere to the treatment. We found that out in our treatment of diabetes. In the old pre-insulin days, the only treatment was to cut the sugars and starches to a minimum place in the diet, and substitute bulk of a hateful variety. This induced such a state of acute dissatisfaction among the sufferers, that only a few could be persuaded to stick to the diet. Happily now the use of insulin has enabled the diabetic to have an approximately normal diet. Therefore there are better and more lasting results if the diet for the over-weight remains normal in quality, and stress be placed rather on the amount. We may rely then on the assurance that a properly arranged diet, assisted by a normal metabolic activity, must of necessity result in normal weight.

The Tod Home

DOROTHY WINDLEY, R.N.

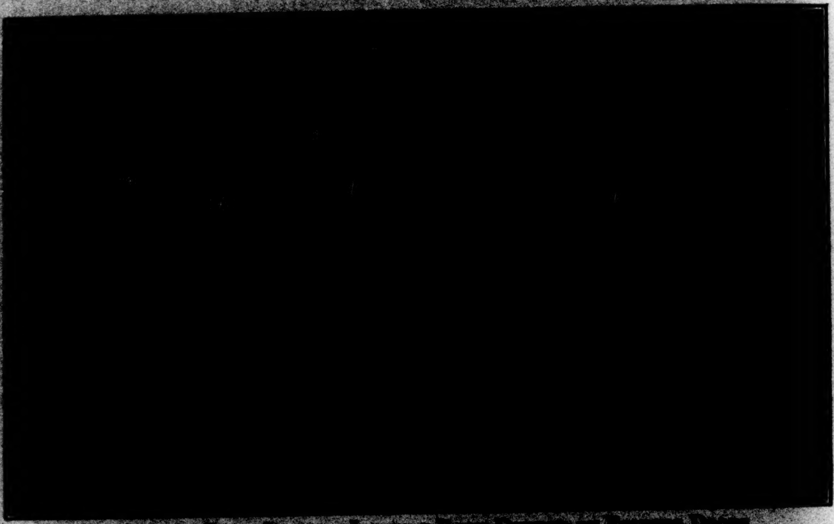


THE TOD HOME

THE Tod Nurses' Home is a part of the New North Side Unit of the Youngstown, Ohio, Hospital which is a private patients' pavilion and is beautifully located on a bluff, permitting extensive views from many of the windows. The Tod Home, with all furnishings and equipment, is the gift of Mr. and Mrs. John Tod. Mr. Tod is Vice President of the Youngstown Hospital Association. The Home, which will accommodate 100 nurses in single and double rooms, is connected with the hospital by a corridor which, like the basement, is partly above ground.

LARGE LIVING ROOM WITH SMALL VISITORS' ROOM BEYOND

A considerable number of graduate nurses are employed, as is desirable in order to stabilise the service, in the New Unit. Only Intermediate and Senior students are sent to this department by the School of Nursing, which is situated in the South Side branch of the Youngstown Hospital.



[illegible] Room Showing [illegible] Doors

The life of the home, therefore, is planned for the happiness of graduates as well as of students.

The weekly social evening is quite popular. Groups of four nurses assume the pleasant responsibilities of hostesses. Cards, dancing, or even sewing, may form the nucleus around which an evening's diversion is planned, the hostesses preparing and serving the light refreshments provided by the hospital at the end of the evening.

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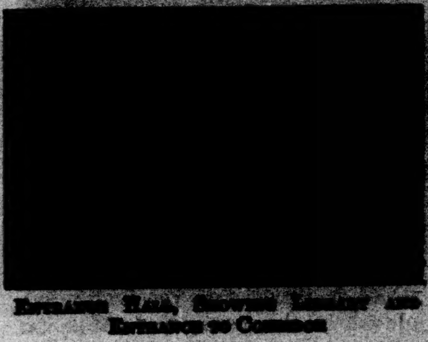


Entrance Hall, Showing Library and Entrance to Corridor

There are always numerous special nurses on duty in the hospital. A large dressing- and rest room is available for them. Showers are provided, and each nurse has an individual locker and key for which she pays a deposit. This is returned when she leaves her case and gives up her key.

The Home, even in the first few months when adjustments of the staff were the order of the day, proved itself worthy in every way to be called a "Home."

The Trials of a Registrar

BY ONE OF THEM

I HAVE learned to recognize them by the tilt of their chic hats, the way they wear their clothes and the sound of their high heels; these are the graduates. Among others there are a few reserved and charming women, but mostly they breeze in like the wind, puff in like a locomotive or limp in like a centenarian. Many of them are elated with self-importance, they dominate the conversation, drag forth all their virtues and produce references which they shake before my eyes. I am dazzled by their conversation, subdued by their virtues and properly impressed by their references.

When one can no longer be amused by things that are amusing and finds oneself bored by things that should not bore, one comes to the conclusion that twelve years are too many for one person to spend in running a nurses' registry.

Such a variety of women in the world; and I am sure that at least one of each kind has taken it upon herself to help humanity by caring for the sick.

It was a wet, slushy day. Snow had been falling, but now the sun was out. The door opened with a rush and closed with a bang, and a beautiful specimen of the profession blew up to my desk with the announcement:

"I'd like to register for city work, please."

"Are you a trained nurse or a practical nurse?"

"Well I most certainly am not a practical nurse."

"A graduate nurse, then?"

"Well no! I am a trained nurse, but I did not graduate."

She was chewing gum and, while waiting for me to get out the necessary application papers, powdered her nose and applied her lip-stick.

"Say! you don't happen to know of any hospital position do you? I been working in a hospital in New York."

"I am sorry, but our hospitals do not employ undergraduates. Just how much training have you had?"

"I have had two and one-half years all together, in three different hospitals. I think a variety is good; it helps one to learn how things are done, don't you think? I get $40 a week for twelve-hour duty, and I don't want any night work."

While this monologue was going on I was observing the self-assured young lady. Beside the things above mentioned, she had on the thinnest of pumps, silk stockings and summer suit, and this was December in Maine. "At least," I thought to myself, "you are not a woman of good judgment, or you would dress according to the season and weather." She wore no rubbers, so her feet were very wet.

"I am sorry," I replied, "but we do not register non-graduate nurses for such a rate; $25 a week would probably be the most you could get, and our work is not twelve-hour work here. I am afraid we can not use you here."

Shortly afterwards she blew out of the office, giving me a most withering look intended to convey the idea that Maine was the loser.

The door quietly opened and two young ladies appeared. They are such a comfort when they look like these,—but clothes, my! my! Was Solomon, in all his glory, ever arrayed like one of these? Squirrel coat and leopard skin, but whether these are owned by the wearers or bought "on time" I know not. They are graduates and bring proof of that fact.

"I will put your names on call at

once. Work is not rushing, but I will do my best for you."

The telephone rings:

"This is Dr. Glidden of Damariscotta. I want a nurse for a mastoid case in our small hospital, and I don't want a red head or any flapper. Be sure and get her off on this next train so she will be here tonight."

"I will do my best, but you have given me only forty-five minutes."

"That should be enough. If nurses were ready, as doctors are, they could start for Europe in forty-five minutes."

"All right, doctor, I will try."

A rush follows to find a nurse who lives near enough to the station to make the train on time. Three are called who have just stepped out; a fourth can't possibly make it in that short time. Finally, way down on the list one is found who hasn't entirely lost the spirit of hurry. She is sent, post haste, and I remember (alas, too late!) that she has red hair. I can imagine how the fur will fly when he sees her. "Well," I sigh, and secretly feel glad that he is so far away that he will probably not call me up about it, especially if she makes good.

Again my office door opens and Miss Susan Andrews comes in. Susan is tall, thin and angular. She has a very superior air and informs me that she is to be in our fair city for a short time and would like a few cases, just to keep her hand in. No! she is not a trained nurse, but much better than any trained nurse; all the doctors have told her so, and her patients are always so glad when she comes because she is so dependable.

"How long have you been a practical nurse?"

"All my life, and I don't like to be called a practical nurse because I am superior to such nurses."

"What do you get for nursing?"

"I get all I can. Sometimes I get as low as $25, but I am worth much more. I judge by the case and the condition of the family."

In filling out the application blank, she spells Protestant "Prod." and forgets to fill in her age.

"I hope you will get me work right away, as I am terribly bored with nothing to do."

I explain that work is dull just now, but we will do our best for her.

She glances around, as she goes out, as though doubtful whether she had been wise to leave the registration fee, lest she might not get a case.

The phone again and Dr. Ingalls wants the best practical nurse I have, for a case in the country.

"What is the case, doctor?"

"It's a woman with a nervous breakdown; she has five children and an old father, and her husband is home week-ends."

"Do you expect a nurse to do all the housework for that family and care for a patient with a nervous breakdown?"

"Yes, there isn't much to do. The father helps a lot, and the oldest girl, thirteen, washes the dishes. This girl and the oldest boy go to school, but the other children are at home."

"It looks to me about impossible, but I will see what I can do."

"Well they have got to have somebody; what are practical nurses for, if not to do the work? It can't be too much, because this woman has been doing it for years."

"Yes, but you see she is having a nervous breakdown."

"Well, there won't any nurse you send out here have a nervous breakdown from overwork."

At last I find Mrs. Jones, a woman well past fifty, who has been out of work for a long time and needs the money. She is willing to do the best she can. Angels can't do more.

The telephone once more.

"Is Mrs. Blank in?"

"This is Mrs. Blank speaking."

"This is Mr. Adams, 462 Prospect Street. You sent a trained nurse to my wife last week, and I want to tell you that I consider you sent us a very poor nurse. My wife used to be a nurse. She came from a hospital in Buffalo, so we think we know something about trained nurses. We don't believe this one was a trained nurse."

"I am sorry, Mr. Adams, if Miss Sherrer has not made good. You are mistaken in thinking she is not a trained nurse, that is one fact of which we make sure before we send them out. Can I send you someone else?"

"No, thanks! We have a practical nurse now and we are pleased."

While this conversation is going on the nurse under discussion comes in.

"Good morning, Miss Sherrer; that was your recent employer with whom I was speaking. What was the trouble on the case?"

"There was no trouble, Mrs. Blank. Everything was pleasant when I left, but nothing I could do would please the patient. I was there a week and she would not let me give her a bath. She took all her own medicines and kept me running after her little boy, eight years old. She was so impatient that I told her I thought she had better get someone else, or allow me to telephone you, but she would not allow it; nor would she allow me to remain until her husband returned. She was strung up to such a pitch that I thought it best to go. So of course I left, and without any money. I am sorry, but I did everything in that house but nurse, and nothing I could do would please."

The telephone rings.

"This is Helen Collins. Please tell me what number I am? When am I going to get work? If you don't give me something I don't know what I'll do. I am down to my last dollar."

I remembered that she was one of the best dressed nurses I had. I do wish she had saved some of her money for just such slack times as this.

"I am sorry, Miss Collins, but you know when there is a long list, doctors are apt to pick the nurses they know, and I am helpless."

"Well, I must say that I think we have a right to get work when we pay for it." Bang goes the receiver. Another light comes in on the board. This time it is Dr. Morgan, who wants a nurse for his private hospital.

"Whom have you on call?"

"I have Miss Carter, doctor, she has expressed a wish for hospital work. I think she is the very one you want."

"Miss Carter; she is that big nurse from the Central Hospital, isn't she?"

"Yes, doctor."

"Not on your tintype, she talks too much. Is Miss Reardon on call? If she is, send her out."

"She is on call, but she won't do hospital work."

"She won't! Who ever heard of such a thing? Send her out. Tell her I want her."

I turn around in my chair to face a new one who comes from another state, a graduate of ten or twelve years before. I read her application and find she wants no contagious, obstetrical or hospital cases, no night work, and nothing outside of the city.

"I will be ready for work tomorrow. Be sure not to call me at night. I hate to get out of bed to go to a case. I have done my share of hard work; let the younger girls take them."

Over the phone comes this:

"Hasn't anything turned up yet? Mercy, I have been on call two weeks. You have just got to give me a case, for I'm buying a fur coat. It cost $220, and I don't want to lose it."

"Why did you buy such an expensive coat? Nurses should live within their means."

"Say, where did I ever hear that before? Everybody has a fur coat, and if you would keep me in cases, as you are supposed to do, I'd be all right." Bang goes the receiver."

An imposing lady of about forty-five sails in. She has a most queenly manner and, as she approaches me, I feel like rising and bowing very low to Her Majesty. I feel very small in spite of my more than 150 pounds. I refrain from rising, assume all the dignity of which I am capable, and listen. Her Royal Highness speaks:

"I am looking for a nurse to go into my daughter's home and care for her two children while their mother goes to the hospital."

"I think we can supply you with just the one you want. I have a Mrs. Martin who is fond of children, who has had training, and I know is capable and trustworthy."

"Kindly give me her references. I never employ anyone, either nurse or maid, until I look up their references very carefully."

I give the addresses and phone numbers of some nurses, but I feel in my own heart that I would not go to care for her darling grandchildren for all the money in the world.

Next Miss Eager enters the office. She is such a sensible-looking woman, the kind you feel you can lean on in time of trouble. I know if I were ill I would like to have her care for me.

"There isn't a single reason why I should come in here, Mrs. Blank, except that I want to tell you about my last case, and—"

"Excuse me, the telephone":

"This is Mrs. Parker, 1426 Winter Street. Can you get a nurse to me right away, within five minutes?"

"I will get one there as quickly as possible, but it may be a little more than five minutes."

"All right, don't send an old girl."

I call up several nurses but, as it is the lunch hour, they all seem to be out. I turn to Miss Eager and, getting out her card, I see that she is thirty-one years old, and I wonder if by any chance she could be considered an "old girl!"

"Could you go to a case right away, Miss Eager?"

"Surest thing you ever knew; I'll take a taxi right home, get my grip, and be there inside of half an hour."

The door opens and a young man comes in and asks the whereabouts of a Mrs. Ruby Marshall. I remember, just in time, that Mrs. Marshall has told me that she did not care to have her husband know where she was, as she had left him and did not want him to bother her on her cases.

"Are you Mr. Marshall?" I inquire.

"I am," is the positive reply.

"I am afraid I can't give you the information you require, as your wife particularly expressed the desire that I keep her whereabouts a secret for the present."

"I simply must find her. You have no right to refuse to tell me where she is."

"Very well, Mr. Marshall, if you will return here at five o'clock, I will give you the required information."

With that he went away, not altogether pleased, but passive. When he returned at five o'clock he had with him a dear little son, about six years old.

"Mr. Marshall, if you will step into the adjoining room you will find the information you require."

He enters the room, the door closes, and I give a sigh of relief. There is another exit from that room, and before long I hear that door open and close, and Mr. and Mrs. Marshall go out together.

Venereal Diseases

Part I—Syphilis

MARION CRAIG POTTER, M.D.

THIS is not a treatise on venereal diseases; the subject is too broad and data too changing. Its object is to refresh the mind in regard to symptomatology and to focus attention upon the revolutionary aspects of diagnosis and treatment since the specific organisms which cause the infections have been isolated; also upon the need to stress, in the education of the general public, facts regarding the prevalence and menace of these diseases. Women especially have too long been kept in ignorance of their real nature.

The nurse, whether a private duty, an institutional, or a public health nurse, holds a strategic position in this field of education because of her intimate contact with the family circle and the authority given her through her connection with the Department of Public Health.

The venereal diseases are contagious diseases, all preventable, and at present they are considered a major problem in preventive medicine. In regard to their incidence, the New York State Department of Health, which coöperates with the U. S. Public Health Service at Washington, D. C., has issued a pamphlet through its Social Hygiene Division stating that venereal diseases headed the list of communicable diseases in New York State last year, and that they are most prevalent between the ages of fourteen and twenty-two, the very threshold of manhood and womanhood.

From the Sanitary Code established by the Public Health Council of the State of New York we quote:

Regulation Twenty-one.

Chancroid, gonorrhoea and syphilis cases to be instructed, forbidden certain occupations, and otherwise restricted. Records not to be disclosed.

It shall be the duty of the physician on the occasion of a first visit to or by a person suffering from chancroid, gonorrhoea or syphilis to instruct such person in the precautions to be taken to prevent communication of the disease to others, and to inform him of the necessity of continuing treatment until cured, and further to give him a circular of information and advice issued or approved by the State Commissioner of Health.

No person suffering from the acute form of gonorrhoea or syphilis shall engage in any occupation involving intimate contact with children, or in the occupation of nurse, domestic servant, barber, hairdresser, chiropodist, manicure, bath attendant or masseur. When such person otherwise conducts himself so as to become a menace to the health of another person, the Health Officer may cause his isolation as defined in Regulation Fourteen of this chapter, for such a period as the Health Officer may deem necessary.

Records of the State Department of Health or of any local Department of Health, or of any local Health Officer, relating to cases of chancroid, gonorrhoea or syphilis, shall be absolutely confidential except insofar as may be necessary to carry out the provisions of the public health law and this code.

Dr. Vernes, Director of the Institute Prophylactique, Paris, the purpose of which is the "extinction of syphilis," makes the statement that one and a half million of persons of the French population died in the past ten years from syphilis alone, not including premature births and stillborn babies—as many as were killed in France in the four years of the World War. The sufferings of those physically maimed in war cease with their death; not so, however, with the great mass of humanity whose lives are destroyed or handicapped by syphilis, for the organism continues its destructive progress, leaving a trail of

diseased wives and children unto the third and fourth generation.

Venereal diseases (named from Venus) are usually contracted by promiscuous sex relations or promiscuous love-making, but as they are often due to innocent or accidental contagion, they constitute a social danger of the first order. They are: syphilis, gonorrhoea and chancroid. Each is a separate disease, due to a distinct microscopic organism, and characterized by definite clinical symptoms. A person may suffer from one or all at the same time. To have had a venereal disease is no protection against another attack.

The older medical authorities, through experimentation and keen observation, had arrived at important conclusions in regard to their dissemination and communicability. Further knowledge of their pathology and scientific proof of their deep-seated nature and widespread significance have been made possible by modern laboratory methods.

Syphilis, or lues, was first recognized as a venereal infection late in the fifteenth century, when Columbus returned from America, at which time there was a serious epidemic following the siege of Naples. It was so common as to be called, in European countries to which it had spread, the Neapolitan disease, and was considered a great disgrace. Mercurial ointment was called Neapolitan ointment and, with other preparations of mercury, was the remedy relied upon for centuries to cure the disease.

Syphilis is a chronic, infectious disease, due to the treponema pallidum. It is acquired by direct or indirect contact or transmitted from the mother to the child. It may invade every organ and tissue of the body, producing destructive changes that simulate any known disease. Six per cent of the cases, even in men, are due to accidental contagion, and the number of innocent wives suffering from the trouble constitutes the greatest martyrdom of women in the history of the world. It is a social scourge.

In 1906, the spirochaeta pallida, or the treponema pallidum, as it is called, the specific organism of the infection, was isolated and found to be readily discernible under the dark-field illuminator of the microscope, making diagnosis possible in the early stages of syphilis and in congenital cases. In 1907, the Wassermann test made possible the discovery of the infection in the blood, and in the brain by spinal puncture and examination of the cerebrospinal fluid of persons affected. To check on the Wassermann we have the Kahn, the luetin and other tests. The tests are not infallible but, when positive, are greatly to be relied upon. A biopsy may disclose the treponema pallidum in the lymph-nodes or gummatous swellings.

The Roentgen ray is useful in distinguishing trouble in the large blood vessels, the bones and, frequently, the stomach.

The course of syphilis naturally divides into three clinical stages, the primary, the secondary and the tertiary. (Some authors speak of the terminal stage as the fourth or quaternary stage.) The chancre, or primary stage, consists of a small ulcer which appears at the site of infection, about three weeks after exposure. It is usually single, but may be multiple. It is painless, often insignificant in appearance, even unnoticed at times. The secretion from it is very contagious. It persists about six weeks and leaves a small, shiny scar. Destruction of the chancre by excision or cauterization will not stop the progress

of the disease, as the organism begins immediately to multiply in the blood. Every sore with a hard base like a split pea should be regarded with suspicion and carefully examined, especially if there is swelling of the neighboring lymphatics.

The chancre may occur, and syphilis result, if the treponema pallidum comes in contact with an abraded surface anywhere on the mucous membrane or on the skin. The skin or mucous membrane must be broken to be infected by the organism. Physicians and nurses have often been infected through abrasions on their hands. The most common of all extragenital lesions are on the lips, from the use of common cups, the interchange of cigarettes, and kissing. Schamberg reports an epidemic of chancres from kissing following a Christmas mistletoe party. "The source was a young man who had a chancre of the lip. Six young women kissed by him developed chancres on the lip. Another young man developed a chancre on the lip, apparently, from the virus deposited on the lip of one of the young women. In addition, a young woman who was kissed by the offender at a third social affair was inoculated, making, in all, eight labial chancres from one source; and later Schamberg was consulted by another girl who had acquired a chancre of the cheek from a kiss from one of the aforementioned young women." Many babies in the cradle are infected in this manner. Kissing is dangerous!

Prior to the discovery of the *treponema pallidum* the question of a chancre was doubtful and, if syphilis were suspected by the physician, the generalized symptoms of the secondary stage were allowed to develop before treatment was begun, in order to be sure of the diagnosis. Today, if it is syphilis, the microscope reveals the organism in the chancre, and the Wassermann test of the blood gives confirmatory evidence of the disease, making immediate treatment not only possible but imperative. Early vigorous treatment is a life-saving measure for the patient and prevents danger to others by speedy cure of the open lesions. An intravenous dose of arsphenamin will often clear up visible lesions within a week.

The secondary stage in untreated cases appears in the course of two or three months. It is ushered in by constitutional symptoms, muscular pain, persistent headaches, especially at night, gradual decrease in weight, and marked anemia. The nails may be affected and there is often temporary loss of hair, even of the eyebrows, giving a moth-eaten appearance to the head. Eruptions, known as syphilides of the skin, of a roseolar and macular type, appear on the body. Following these eruptions, or merging with them, are papules of a dusky brown color which are followed by pustules. All are more or less indurated. They fade on pressure, do not itch and, unlike most other eruptions except some forms of chronic eczema, are found on the palms of the hands and the soles of the feet. They run their course in from three to nine months. Even to physicians, the rash is often confusing, but finding the treponema pallidum under the microscope, or a positive Wassermann, clinches the diagnosis.

In the secondary stage, lymphatic nodes are found all over the body, but in syphilis they rarely suppurate. Associated with the enlarged lymphatics and the manifestations on the skin is an inflammation of the throat and mouth with ulcerated areas, on the lips and tongue, known as mucous patches. Later, mucous papules and condylomata are common around the rectum

and, like the mucous patches on the lips, they swarm with the organisms. If a person acquires the disease from the secondary lesions, which are very contagious, a true chancre follows, resulting in syphilis.

The second stage may be mild and gradually disappear; however, serious complications sometimes develop with fatal termination, known as malignant or galloping syphilis.

An intermission of symptoms follows the secondary stage, and the patient considers himself well. The skin clears up; the swollen glands disappear, except possibly the post-cervical or epitrochlear glands in the elbows which are the only exterior manifestation left of the infection; the mucous membranes heal; and the hair returns as luxuriant as ever. The patient considers himself well. In the course of three to five years the treponema pallidum loses its virulent and contagious character and becomes practically innocuous to others. For this reason many wives escape and children are spared. It is a deceiving and treacherous period for the individual, for if the disease has not been exterminated by specific treatment, the organisms slowly colonize in different parts of the body and, though concealed and apparently inactive, pursue their relentless course.

The tertiary stage may develop within one to forty years. It usually becomes manifest in seven to eight years, although brain syphilis has been known to appear within eight months. The lesions of the third stage are known as gummata. These brawny swellings may attack any organ of the body, often developing under the skin or in cartilages. Breaking down, they cause very disfiguring ulcerations and scars, especially on the face. Although the most severe symptoms may improve or recover under treatment, the lost tissue, such as a blinded eye, a sunken nose, or a perforated palate, cannot be restored.

In the tertiary stage, the arterial and nervous systems are likely to be affected. Among the neurosyphilitic diseases are locomotor ataxia, with its years of helplessness, and paresis or softening of the brain, which runs its fatal course within a few years. The patient has delusions of grandeur and his extravagance, before his mental condition is discovered, may plunge his family into great financial distress. Twenty per cent of the patients in hospitals for the insane are reported as syphilitic.

In the third stage all lesions are progressive and destructive, often being so deforming that the victims are found in institutions or shrink from the public and lead secluded lives.

Persons having had syphilis are considered such poor risks that they are only accepted by life insurance companies at an increased rate of premium.

According to Hazen, there are probably about eight million syphilitics in the country, while mortuary reports show that syphilis does not cause more than three thousand deaths a year. He states that we are probably justified in assuming that, in subjects less than forty-five years of age, syphilis causes all deaths due to apoplexy and angina pectoris and is the indirect cause of death in a great many cases of heart and kidney diseases, as well as aneurysm, cancer of the mouth and cirrhosis of the liver, making at least twenty-five thousand deaths annually from the disease. The economic loss to the country is estimated in the millions (for clinics, insane hospitals, institutions for defectives, etc.), but what is economic loss compared with the toll in human life and happiness!

Chancroids should not be confused with chancre, the former being multiple ulcers due to a different organism, the bacillus Ducrey. Chancroids are venereal sores, with profuse discharge, developing a few days after exposure. They are accompanied by enlarged lymphatics in the groin, which often suppurate. They are a local condition and are cured by proper local treatment. Chancroid is often wrongly called "soft chancre."

Congenital syphilis is due to the same germ as the acquired, the treponema pallidum. Infected so young, the child is at a great disadvantage. Specific remedies are not so effectual as in adults. As the disease is contracted in the uterus through the placenta of the mother, there is no chancre or primary stage. It begins with secondary symptoms, irritation of the mucous membrane of the nose and throat, called snuffles, skin eruptions, falling hair, swollen glands and other constitutional defects. It is very contagious during this active stage. There are numerous instances of infection of a healthy wet nurse from the mucous patches on the lips or tongue of a baby.

About one-third of syphilitic parents fail to have living children; one-third of the children die at birth or soon after. Autopsies show every organ of the body involved. If they survive infancy, they may have systemic disturbances. As children, they are poorly developed both mentally and physically; retarded in growth, with pinched and drawn faces, giving them a senile appearance. In better nourished children, or in possibly a less virulent strain of infection, the disease may be dormant until puberty or later, when symptoms develop analogous to the tertiary stage, among which are skin diseases which are intractable and difficult to cure. A group of symptoms known as Hutchinson's triad is very diagnostic of congenital syphilis. These are notched teeth, sudden deafness, and interstitial keratitis. About 13 per cent of blindness is due to syphilis.

The presence of scars resembling purse-strings about the mouth, called rhagades, are highly suggestive of congenital syphilis.

A part of the prenatal care of every pregnant woman should consist of a routine Wassermann test. If it is positive in its reaction, prompt and specific treatment may save the health of the mother and the life of the child. In a series of fifty thousand such examinations, 7 per cent were reported positive.

No disease is so well understood and none has a therapy more specific than that of syphilis.

Great advance was made in the treatment of syphilis when Ehrlich discovered in 1909 that preparations of arsenic, such as salvarsan or "606," would destroy the treponema pallidum without injuring the patient.

At present the generally accepted treatment consists of courses of intravenous injections of arsphenamin or neo-arsphenamin, followed by intramuscular injections of mercury or bismuth, combined in the late stages, with iodids by mouth. The treatment covers months of time, during which there must be repeated Wassermann tests of the blood and the spinal fluid. It is considered by some syphilographers that the treatment should be continued for a year following negative results of these tests. Malarial therapy is being used in institutions for neurosyphilis with encouraging results.

The whole question is an international one. At the present time there is no universally accepted and standardized treatment, as shown by

the following report of the Health Organisation of the League of Nations, of which Surgeon General Hugh Cumming is a member. A group of experts was appointed by the president of the Health Organization to study the treatment of syphilis and its results. The following is included in the summary of their report:

The results in the fight against syphilis have not been so great as the progress of syphilis therapy would give reason to expect. The explanation suggested by the experts was that advances in the diagnosis and therapy of syphilis have not been exploited everywhere so rapidly and effectively as would be desirable, and a generally recognised uniform method of treatment did not exist. For this reason it was suggested that a statistical compilation of the various methods of treatment in clinics and dispensaries might convey a better idea of the efficacy of these methods. The two purposes for which treatment is given should be borne in mind: first, the rapid and effective suppression of contagiousness; second, the protection of the patient from the severe late effects of syphilis. For these reasons a retrospective enquiry was recommended. . . .

The Health Committee approved these proposals and the clinics and dispensaries are being selected to participate in the enquiry in Denmark, France, Germany, Great Britain and the United States of America, where the enquiry centers in the United States Public Health Service. The American Committee on Research in Syphilis, a private organization, will help in the enquiry and, in coöperation with the expert appointed by Surgeon General Cumming of the United States Health Service, will select the clinics which are to be invited to participate.

From the Days of Long Ago

ELSIE PAISLEY, R.N.

ELIZABETH GLENN suppressed a little sigh as she drew the comb through the faded yellowish hair of old Mrs. Keiser. What a pity that hair like that couldn't be hidden under a dainty cap, such as the one in the little picture of Florence Nightingale on the wall. Strange, to find her picture in such surroundings; but the old lady was an Englishwoman and the picture was, no doubt, a relic of her days at home.

Remembering that her duty as a county nurse was to be pleasant, Elizabeth asked cheerfully, "How do you happen to have a decidedly German name with your English accent?"

The patient gave a little gasp of pain as she moved, before she began. "You see people used to stop in to have me look after their hurts such as cuts, sprains, and burns. One day Keiser came past, in his meat wagon, and he had torn his hand rather badly on a wire. I removed the filthy dressing, cleaned the wound with an antiseptic and bandaged it for him. Naturally, he was very grateful, and he began bringing me fruit and vegetables and flowers from his garden. He just kept at me, until I finally married him."

Miss Glenn ventured to relieve the short silence that followed by asking, "Then you really enjoy playing nurse to your neighbors when they are in trouble? Did you ever wish that you were a real nurse? I fancy you might have liked being a public health nurse."

Mrs. Keiser laughed dryly and said, "I was a nurse, though you wouldn't have called it public health nursing in those days. We went from house to house and nursed the poor who were sick. A committee of women looked after us. They furnished us with a house and material to use in our work. We got a pound a week. I had training, too."

While the astonished nurse shook up the pillow, Mrs. Keiser continued, "I trained at Bromlow Hill Parish Infirmary, in Liverpool, England. We wore white aprons, with bibs, caps of white net, and pink cambric dresses. And oh, it used to be awful! The patients kept cake and candy under their pillows, and no matter how sick they might be they were allowed to spread the cakes and candies on the bed and barter them to other patients for a ha'-penny or a penny a piece. And there were bed sores this big." Gestures were used to make the size of the sores more vivid. "We had one building for typhus, one for scarlet fever, one for typhoid, one for smallpox, and so on." As she catalogued the contagious diseases that were all too common in her day, it was easy to picture the rambling old buildings that made up the Bromlow Hill Parish Infirmary. As if talking to herself, Mrs. Keiser rambled on, "Those nurses were a bunch of gay young scamps. Nursing was about all a woman could do in those days. Every nurse had to be on night duty for three months, and some of those scoundrels would write things on the night report that did not even happen.

"Each nurse had to serve a year as a probationer under other nurses. The last two years of her training she had charge of a ward of her own, and sometimes had other nurses under her.

"It never was the way it should have been at Bromlow Hill, but before I left there were nurses coming down from St. Thomas', in London, to help out. Miss Agnes Jones came to take charge of things. Sometimes a rather small, gray-haired woman came to see how we were getting on, and we thought her strict. She taught us to use alcohol and this white powder—what is it you call it? (Elizabeth Glenn supplied the missing name for the powder)—for bed sores. After she came the beds had to be changed often, and the patients were not allowed to keep any food under their pillows. We had lectures by this friend, occasionally, after Agnes Jones took charge of us."

Without warning, Mrs. Keiser staggered out of her bed to rummage in the old trunk that was at the head. She might have been looking for woolens, from the odor of moth balls, but she announced her disappointment at not finding a newspaper clipping. "Sorry I can't find that clipping. *She* believed in public health nursing much as you are doing it."

Elizabeth was about to ask who "she" was, but Mrs. Keiser's eyes were intent upon the picture of the face that was so sweetly framed in the cap. In the rather crude drawing, the woman carried a lamp, and was looking with kindly interest at a sick soldier in his chair. Elizabeth exclaimed, "You mean it was Florence Nightingale who came to Bromlow Hill and made it livable?" "Yes," admitted Mrs. Keiser, "I trained under Florence Nightingale."

"Well, of course a few lectures wasn't exactly training, but it is interesting just the same," thought Miss Glenn, as she finished her visit and started for home. How fragrant the honeysuckle seemed after the stuffy room.

When she arrived at her own cozy room, the first thing she did was to hunt out old notebooks from Teachers College. Sure enough, Miss Nightingale had gone down to help Agnes Jones after she took over the infirmary in Liverpool. A freshly dusted copy of "The History of Nursing" found a place beside a new novel within the brass book ends on her table. Not romance, but reality, had given her a new glow of interest in the subject.

Educational Background of 63,000 Students

NEBRASKA leads all other states in the Union in the per cent of student nurses reported in the Grading study as having had four years or more of high school before entering training. Second in rank comes Oregon; and third, Minnesota. In each of these three states 90 per cent or more of the student nurses so reported have finished four years of high school. At the foot of the row come New Jersey and Delaware, with 46 per cent, and Arkansas, with 41 per cent. The middle state is Louisiana, where 73 per cent of the student nurses are reported as having had four years or more of high school.

In the spring of 1927 the Committee on the Grading of Nursing Schools tabulated facts concerning the educational background of 6,756 nurses in private duty, public health, and institutional nursing. Of the 2,206 nurses in this study who had entered the profession within the previous five years, only 56 per cent had finished four years of high school; and these probably represented those slightly above the average for the whole 0–5 year group. The present study, for 63,088 students in nursing schools last May, shows 73 per cent who have had four years of high school or more. Those who are working with the figures believe that standards for entrance to nursing schools have risen very rapidly within the past three years.

These are the first nation-wide returns from the Grading study. The results are shown in more detail in the table and diagram accompanying this article. In the case of four states —Wyoming, New Mexico, Arizona, and Idaho—where returns were secured from not more than three schools each, and the number of student nurses was small, figures for the entire group have been combined. They have one rank, 34, under the caption "other."

While several individual states do far better or far worse than their neighbors, the diagram, nevertheless, shows a rough agreement between the different states in each of the main geographical divisions. If we add the rank as shown in the table for each state in each of the five main geographical divisions, and then divide the total by the number of states in that division, the result is an average rank for the division. The results of such average rankings are as follows:

	States	*Average rank*
North Central..........	12	10.5
Western..............	10	16.1
South Atlantic..........	9	25.9
North Atlantic..........	9	31.6
South Central..........	8	34.9

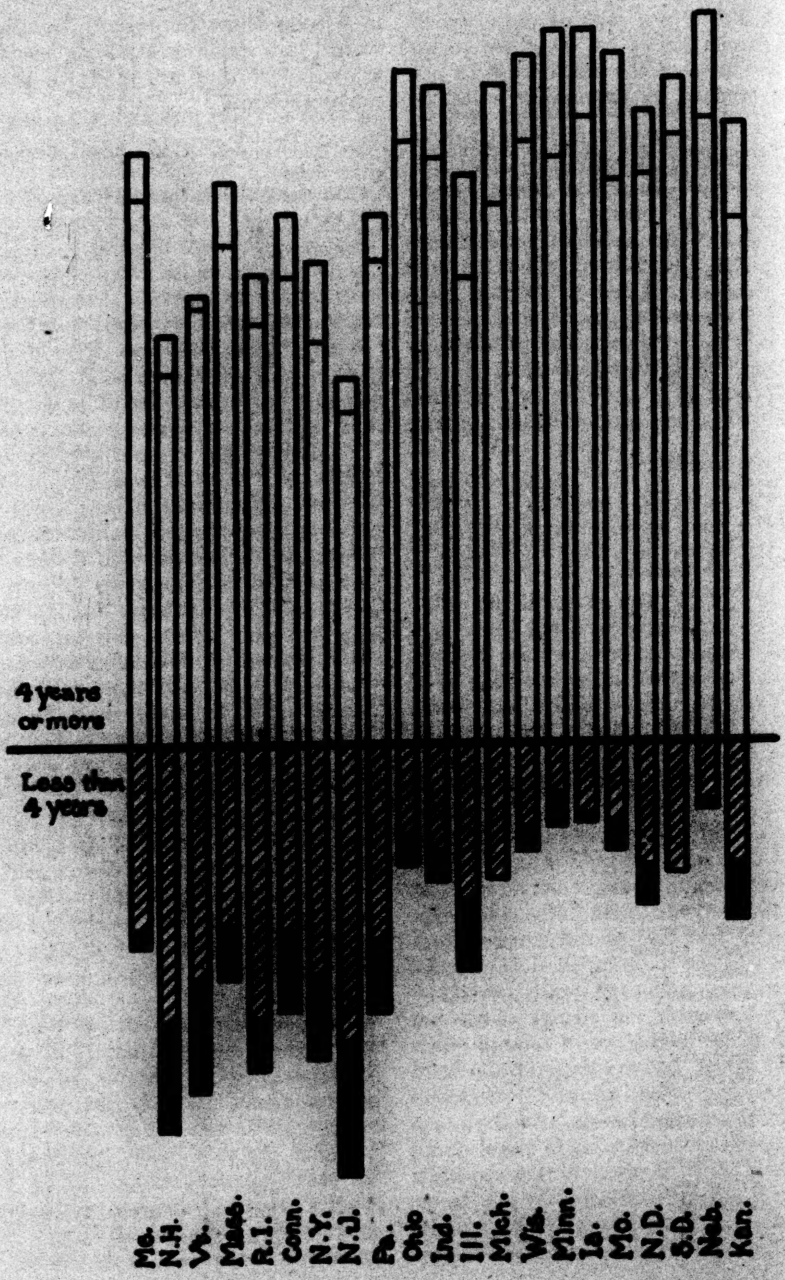
In the diagram the heavy black line across the page separates the per cent of students in each state who have had four years of high school or more from those who have had less than four years. The bar across the top of the column shows the per cent of student nurses who have had some college education. The shaded portion below the horizontal line shows the per cent of students who have had two or three years of high school; while the solid black portion shows those who have had one year of high school or eighth grade or less.

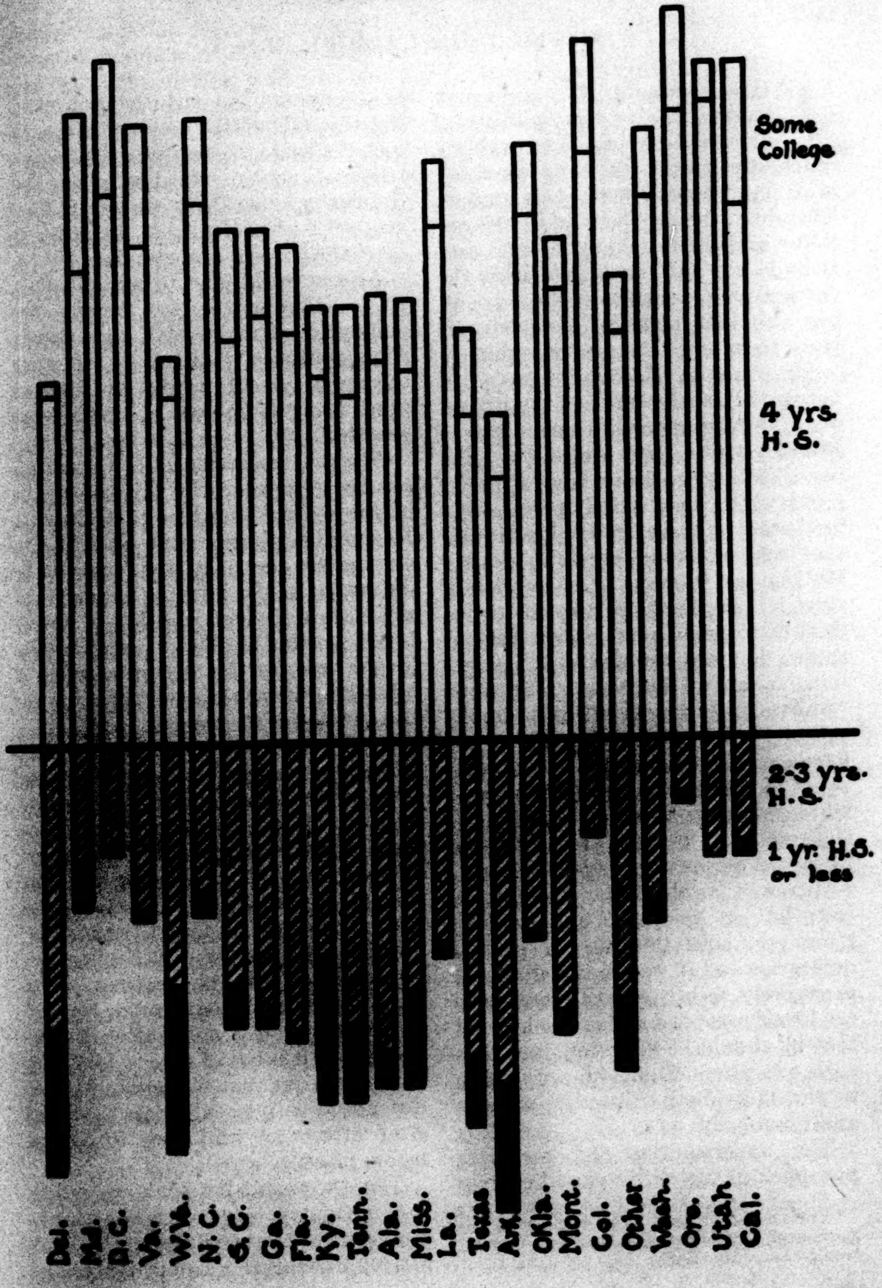
The Grading Committee is gathering these figures not only for each state, but for every school which has joined in the self-grading study. The questions for nurses everywhere to ask are: first, why do some states rank so much lower than others; and second, what per cent of student nurses should we expect to have four years of high school? What is the proper standard towards which all states should strive?

Is it the 90 per cent or more which has been reached by the three states at the head of the list, or the 73 per cent reached by the middle state; or is it somewhere between? In other words, how much do students need to know before they are ready to enter nursing school?

STATES ARRANGED IN ORDER ACCORDING TO THE EDUCATIONAL BACKGROUND OF 63,088 STUDENT NURSES IN SCHOOLS JOINING IN GRADING STUDY.
(NOTE: Wyoming, New Mexico, Arizona, and Idaho are combined under "Other".)

Rank	*State*	*Schools*	*Students*	*Per cent Four Years*
		Taking Part		*High School or More*
1	Nebraska	19	843	92.39
2	Oregon	9	479	91.69
3	Minnesota	52	2,907	90.33
4	Iowa	41	1,677	89.78
5	Colorado	21	785	87.95
6	Wisconsin	40	1,725	87.50
7	Missouri	30	1,535	86.90
8	D. C.	13	866	86.38
9	Ohio	73	3,868	85.22
10	California	52	2,809	84.97
11	Utah	4	184	84.53
12	South Dakota	15	343	83.82
13	Indiana	26	1,430	83.13
14	Michigan	46	2,288	82.82
15	North Dakota	14	518	79.92
16	Maryland	23	1,321	79.90
17	North Carolina	29	727	79.00
18	Kansas	32	867	78.15
19	Virginia	38	1,197	78.04
20	Washington	22	1,020	76.87
21	Maine	22	540	75.10
22	Oklahoma	17	388	74.73
23	Louisiana	16	763	73.13
24	Illinois	101	4,774	72.49
25	Massachusetts	87	4,238	70.95
26	Pennsylvania	143	7,132	67.65
27	Connecticut	20	1,261	67.01
28	South Carolina	13	367	65.85
29	Georgia	27	849	65.02
30	Florida	14	516	63.20
31	Montana	15	347	63.01
32	New York	133	7,241	60.75
33	Rhode Island	10	434	58.84
34	Other	9	199	58.29
35	Alabama	21	572	57.27
36	Vermont	7	167	56.89
37	Mississippi	16	209	56.50
38	Kentucky	16	462	55.31
39	Tennessee	17	709	54.83
40	Texas	54	1,546	51.96
41	New Hampshire	19	377	51.89
42	West Virginia	24	507	49.41
43	New Jersey	36	1,600	45.83
44	Delaware	6	167	45.78
45	Arkansas	17	334	41.45


4 years or more
Less than 4 years
Me.
N.H.
Vt.
Mass.
R.I.
Conn.
N.Y.
N.J.
Pa.
Ohio
Ind.
Ill.
Mich.
Wis.
Minn.
Ia.
Mo.
N.D.
S.D.
Neb.
Kan.


Some College
4 yrs. H. S.
2-3 yrs. H. S.
1 yr. H. S. or less
Del.
Md.
D. C.
Va.
W. Va.
N. C.
S. C.
Ga.
Fla.
Ky.
Tenn.
Ala.
Miss.
La.
Texas
Ark.
Okla.
Mont.
Col.
Other
Wash.
Ore.
Utah
Cal.

Adult Education[1]

SISTER JOHN GABRIEL, R.N.

THE leaders in the profession have at heart the uplifting of its members and they are very much alive to the fact that education is an important factor in this process. Therefore, the problem before the national and the international organizations is not only concerned with the entrance requirements of the student, but also with plans to complete the basic training of the graduate nurse.

Dr. Burgess' discoveries have led her to the conclusion that the undereducated, unprepared woman makes trouble within the profession. She says, "Many are drawn from a special group which is not strictly professional in character; these are the individuals that talk unions and tear down ideals." Be that as it may, it is commonly agreed that there are two requisites that distinguish a profession from a trade; they are knowledge and a certain amount of idealism. The word "profession" carries with it an implication of higher education and of refinement of manners that is an evidence of the development of powers of mind above the average.

There was a time, even in the history of our own country, when education was for the few. The masses were left in ignorance and slavery; moreover, education was a private enterprise and it was confined almost exclusively to boys, until more modern ideals prevailed and it was insisted that all should be educated, and that such education should be serviceable to the individual culturally, socially and practically.

The opportunities and resources now open in the richly varied courses of the numerous institutions of learning throughout the country are a direct challenge to every nurse, as a professional woman, to make up any deficiency in her early education, be it academic or professional, in order to meet the present-day standards.

All the world goes to school today. The classroom is no longer the monopoly of childhood and youth. Along with the traditionally reluctant throng of young people we find an eager army of mature students from practically every walk of life.

The movement for adult education has been quickened by the discoveries of Professor Thorndike of Columbia University, whose recent experiments emphasize the fact that the only difference in the learning capacity of the mature student and that of youth is the question of time. It may take a longer time for the former to grasp a bit of knowledge than the latter but he has the power to grasp it.

Professor Thorndike favors adult education and gives the following reasons for his preference: (1) persons may be better selected; (2) abilities may be better discovered; (3) content of instruction may be better thought out; (4) the need may be better satisfied; (5) the loss by forgetting may be avoided; (6) the lag of schooling behind science may be lessened. The same author holds that what is learned at ten or twenty must often be relearned, or it is out of date at forty; he also points out that the public welfare depends as truly on who goes to school after fifteen as who goes to school before fifteen.

The movement for adult education in this country, however, is not merely a movement to rescue those who have arrived at mature years in ignorance.

[1] From a paper read at a meeting of the Northwest Division of the American Nurses' Association, July, 1930.

Adult education includes a continuation of training of the professional groups. The medical men who stand so high in the professional world have thought it no reflection on their previous training to organize short courses in various subjects that they may again sit at the feet of brilliant minds, and of men who have discovered new things in medical science; consequently each year on the campus of several universities in this country institutes for medical men are being held as well as institutes for graduate nurses. Very busy men attend these institutes in large numbers. Why do not our graduate nurses attend their institutes in equally large numbers?

In addition to these institutes for nurses there are summer courses, extension courses, and conferences of every description to make it possible to keep the torch of progress burning throughout a professional career if the individual's aim is to give the best that is in her to her profession. But as private duty nurses and sometimes institutional nurses, you may argue that time and money are wanting. That, too, may be adjusted if you will use profitably the periods of release from your duties. Nurses have much free time if they would gather it together and put it to good use. James Bryce says that all of us lose more opportunities than we use, and it is commonly admitted that the busiest person is the person who can always find time to do more. Why not have a correspondence course in English, psychology, sociology, etc., to take up those odd moments that slip away from us so carelessly bringing no returns?

Do you know that you can make one-third of your college work toward a degree, in most universities, through correspondence? If you cannot afford to go away to college, I know of no better way to accumulate college credits.

Courses are available at your own state universities, and you may secure all the information about them for a two-cent stamp. So much on the question of time. What about the financial side of this method of education? That, too, may be adjusted in your favor if you are in earnest. You may write to the dean of women at the university of your choice and ask what is available for a person of your training in the way of work for the number of hours you feel you can give to it each day.

Any university will encourage student help and will pay at least 40 cents an hour for unskilled labor and 50 cents an hour for skilled labor. Elderly people are sometimes situated near the university and apply there for someone to care for them a few hours each day and, again, parents who would like to go out in the evening very often appreciate being able to secure the services of a nurse to care for the children during their absence. Then, too, there are chronic invalids who allow ample free time for the nurse to take a few subjects at the university. I know nurses who take night work on private cases and attend the university during the day; that is, they take their lecture hours before going to bed in the morning and rise early in the afternoon to do their library work and to study. There are many openings on a campus for students who wish work between class-periods, such as the library, cafeteria, registrar's office, printing office, and correcting papers. The ambitious nurse who really wants an education will find numerous ways to finance it.[2] It is said that of the 7,000 or 8,000 regular students

[2] See "Loan Funds and Scholarships" in *Journal* for January, 1930.

attending the University of Washington, one-third are working their way through.

The fact that you have a diploma does not give you a standing for long. There is no magic in a diploma that prevents things from progressing beyond the level they were when you received it. Neither does a diploma guarantee efficiency for life. At most, the nurse's diploma is a passport into the profession, and the profession has the right to expect that the individual nurse will continue to grow and reach out farther and farther into the ever-widening branches of scientific knowledge and technical skill.

The complex system of modern medicine, the constant evolution of nursing, the ever increasing demands for higher educational standards place the responsibility upon the nurse to develop to the highest capacity the powers that are within her, that she may give to the profession a new type of service, not necessarily a better nor a truer service but one which will correspond with the changing needs of humanity and one that is better adapted to the age in which she lives.

It is not the aim, however, nor the ambition of nursing development and progress to cast a shadow on the resolute, adventurous pioneer whose life is full of warm devotion, splendid energy and heroic deeds. No, the pioneer nurse is of that sturdy type that has no fear of exploring new paths that will lead to better service for the sick and to prevention of disease. She knows that the best inheritance that she can carry over from the past is the spirit which has brought her through so many difficult years with such great courage and unshaken faith in the beliefs and principles for which she stands. There is rather an urge for the nurse of today to make use of the inspiring opportunities that are now open before her and an attempt to awaken in her the responsibility that is hers to move on and to continue to improve for the benefit of the patient to whom she owes the existence of her profession. It is for his benefit that she has undertaken her training; not primarily that she might make a living but that she might be able to give him the chance to live and be well.

Work which has no other than a money value cannot bring the satisfaction that the worker craves. I do not mean to reflect upon a nurse for making her profession a means of earning a livelihood, but to choose the career solely for money is to degrade one of the sublimest vocations to which a woman can aspire.

In conclusion, let me warn you that if you want to be a nurse above the average, if you want to keep up with the responsibilities and demands of your profession, you must not be content to sit down and rest where you are. You have done much, it is true, in the process of your training and your later experiences, but your enthusiasm should not for that spend itself in pseudo-congratulations, but should rather direct iself along the path of continuous effort to the full attainment of the desired end—that is, to allow no one in the profession to surpass you in serviceable knowledge, lofty ideals and victorious achievement. Browning says:

> Ah, but a man's reach should exceed his grasp,
> Or what's a heaven for?

Nursing Medical Patients

Problems with Patients Having Basedow's Disease[1]

FLORENCE K. WILSON, R.N.

IN Basedow's disease difficulties with personality become nursing problems, probably because we are dealing with a disease which changes personality. This tabulation does not show such striking personality difficulties as one would expect. It may be that the nurse excuses the personal peculiarities of these patients because she knows they are caused by the disease. Because she does this, they do not appear to her as difficulties.

The case report chosen for Basedow's disease is not strictly medical as it was necessary to give surgical treatment.

Table No. 5—Problems in Nursing Patients with Basedow's Disease

Difficulties in giving nursing care		29
To keep quiet in bed	15	
To give medications	2	
To prevent decubitus	2	
To urge food	2	
To keep comfortable	1	
To avoid irritating patient	1	
To keep quiet before basal metabolism test	1	
To satisfy patient's wants	1	
To keep mouth clean	1	
To overcome objection to baths	1	
To keep cool	1	
To stop nausea	1	
Difficulties with personality		7
To keep patient from worrying	2	
To overcome desire to go home	2	
To help persuade patient to consent to operation	1	
To overcome language difficulty	1	
To deal with an ignorant patient	1	

Problems as Stated by Students

1. It was almost impossible to keep her quiet and in bed. She needed continuous watching and to be spoken to in a firm and stern manner. It was a problem to stop the nausea. Fluids were restricted, dry diet and finally a gastric lavage were given. This did not entirely solve the problem.

2. The chief nursing problem encountered with patient was to make her lie in bed and be quiet. She was very nervous, laughed readily and was always too warm to keep the bed covers over her. She would not eat the meals provided, although the dietitians did all they could to please her, but would eat fancy cookies and candy which her family brought her. These had to be taken away from her before she would stop.

3. The nursing problems presented were not many or difficult. One was explaining basal metabolism to her and making her understand the importance of perfect quiet before going. This I did the first time, then every time after that she comprehended and was very quiet. I would tell her when I took her temperature that she was to go to basal metabolism. Then I pulled the curtains around her bed, told her not to talk and to go to sleep. This she usually did, very promptly turning over and falling to sleep again. Then I left her, returning occasionally to see that she was still quiet. Another problem was the question of operation. It was considered as a possible form of therapy and she was undecided as to whether or not to consent. So I tried to reassure her about it and convince her she should do as the doctors thought best, especially as she was now in the best health possible. I told her about another patient and how quickly she had been able to go home, and tried to make her see it in the best light possible.

4. Making the patient understand English or my sign language. This was her first hospital experience and so she had no background upon which to interpret her surroundings. Keeping the patient from over-exerting herself. In turning from one side of the bed to the other she, because of her condition, used six or eight times as much energy as necessary. She constantly over-exerted herself.

5. I found it rather difficult to care for this patient, since she was rather uncoöperative. She seemed to be very weak and appeared to be sleeping most of the time. It was

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[1] The first of Miss Wilson's articles on Medical Nursing appeared in the *Journal* for March, 1928. Others were printed in May and September.

impossible to interest her in reading and she was far too weak and nervous to sew. At last I found that she was homesick. The social worker went to her home and made arrangements for the family to come down and visit her. This seemed to help some, but even so she longed to be home.

6. The patient is coöperative, but is not very intelligent. She seems somewhat uninterested, but really is worried about her condition. She is continually asking if we can see that her goiter is going down. She is anxious to get back home, due no doubt to the fact that her husband does not come to see her any more. She is somewhat thoughtless, but is not at all difficult to care for. She refuses to submit to another operation because the first one was not more successful, and perhaps more so because she was told this operation would have to be under a local anesthetic, which worries her.

Report No. 7—Study of a Patient with Basedow's Disease

Social History

MRS. ANGELO was born in Italy, but has lived in the United States about ten years and in the city of Cleveland approximately two years. She is of Catholic faith. Mrs. Angelo is married, fifty-one years of age and the mother of eight children: one son and seven daughters. All children are at home except Rose, who is married and lives in the city. All children are in good health except the son, who has had sleeping sickness for the past six years and is unable to work.

Mr. Angelo has poor health and is unable to have steady work and is idle most of the winter. When he does work he averages 50 cents per hour. Mrs. Angelo and the daughters who are old enough to work are apparently the main providers of the family. Mrs. Angelo, previous to her illness, worked in wealthy people's homes, doing general cleaning and garden care. Helen, one of the daughters, has worked up to the last few weeks, but has quit her job and is to be married next month. Catherine, aged sixteen, is very feeble and unable to work outside of the home. Jennie, eighteen years of age, is looking for work, and the other three children are small, still in school, and not able to increase the family budget in any way.

Together they are buying a family house. It is a comfortable five-room house, valued at $6,000. It is mortgaged and, due to so much unemployment and sickness in family, they are afraid they are going to lose the home.

The social worker has only made one call, and as yet does not know the details of their circumstances. However, they expect to look into the family case and make some kind of plans for the family in the future.

Mrs. Angelo was a very nice patient and very coöperative after she understood what you were going to do for her. All you needed to do to make her comfortable and happy was to be kind to her and act interested in her. She appreciated very much everything you did for her, after she understood that no harm was being done.

Medical History

Mrs. Angelo was referred to the dispensary by a social worker on September 1, 1928. She complained of extreme nervousness and irritability, and loss of weight for the last eight months. She also has had palpitation of the heart. The patient said for the last thirteen years she has had a lump on the right side of neck; and within the last eight months the rest of the gland became enlarged and firm. The exact amount in loss of weight cannot be accurately determined. As far as can be ascertained the patient has had no previous iodin therapy. At this clinic the patient was diagnosed as adenoma of thyroid and Basedow's disease. She was referred to the hospital and an operation advised. The patient wanted to go

home and talk it over with the family, which she did. She was then admitted to a medical ward.

Laboratory Findings

Urine—clear, amber color fluid, acid, albumin negative and sugar negative. A few white and epithelial débris.

Blood

Hb.—80 per cent
W. B. C.—5,950
Blood Wassermann—negative
Blood sugar—.119 per cent

Physical Findings

Mrs. Angelo is a fairly well developed, though under-nourished and obviously a hyperactive woman. When she entered the hospital she was not acutely ill, in no pain, had no edema, no dyspnea, but a slight increase in respiratory rate. Her skin shows a brown pigmentation on different parts of her body which is more marked over the chest. The skin shows no cyanosis and has no eruptions. The eyes have good muscle coördination and show a slight exophthalmos. The neck shows a large firm mass in the right lobe of the thyroid with firm enlargement of all the thyroid which moves with swallowing. The heart has good pericardial activity with slight bilateral cardiac hypertrophy. The pulse is abnormally full, but regular and rhythmical. The extremities show no edema, no bone or joint abnormalities, no atrophy or localized reflexes, but are somewhat hyperactive. Mrs. Angelo weighs $92\frac{1}{5}$ pounds and is 4 feet, $9\frac{1}{5}$ inches tall. Blood pressure, $\frac{160}{65}$.

Symptoms

Some of the symptoms I noticed in caring for Mrs. Angelo:

(a) Rapid pulse—120
(b) Extremely nervous
(c) Very easily irritated but calmed down if treated considerately
(d) Restless
(e) Slight tremor of fingers
(f) Slight loss of weight

I think all of these symptoms can be associated with the patient's disease.

Nursing Problems

Mrs. Angelo was given regular hospital care, with no special care except bed-rest and potassium iodid grs. iii, t. i. d. and exopthalmic diet for two weeks. In this length of time her basal metabolism rate came down gradually from 92 per cent increase to 38 per cent increase, where it remained for two successive tests. There was also a corresponding improvement in the clinical appearance of the patient. She was then transferred to the surgery and was prepared for operation. She had a successful thyroidectomy and, after nine days of regular post-operative surgical care, the patient was discharged.

Treatments and Tests by Doctors in Which Nurses Assisted

(a) Venipuncture
(b) Basal metabolism
(c) Routine prep. with s.s. enema
(d) Operation—thyroidectomy
(e) Infusion—2,000 c.c.
(f) Rectal tap. 10 c.c. of tincture of digitalis and 200 c.c. of 5 per cent glucose
(g) Hot dressings to neck q. i. h.
(h) Wheel chair, b. i. d.

Medications

(a) Luminal grs. iss h. s.
(b) Allonal grs. $2\frac{3}{5}$ h. s.
(c) Morphin grs. $\frac{1}{6}$ } h.
Atropine grs. 1/150 }
(d) Morphin sulphate grs. 1/6 h.
(e) Potassium iodid grs. iii, t. i. d.

Mrs. Angelo was given a sedative practically every day at bedtime

which was effectual. The patient had very good nights. The potassium iodid reduced the basal metabolism rate. The M. S. was given to quiet the patient and also to relieve pain, postoperative, and was effectual. There were no difficult nursing problems encountered with this patient. She was very coöperative after she understood that she was going to be treated with care and kindness. I enjoyed nursing this patient very much. At first she was rather difficult to care for, due to language difficulty, but within a day or two I got along nicely with her. She appreciated very much everything you did for her. I enjoyed it, because at first I thought she would be very difficult to handle and care for, but soon found out that she was one of the most interesting patients.

PLANS FOR PATIENT

After Mrs. Angelo was discharged from the hospital, she was asked to return to the dispensary on the 22nd day of October, which she did. In examination, this day, she said she felt very well, has slept and eaten well since she was discharged. She complains of an occasional burning pain in the scar, but otherwise feels fine. The wound is very well healed. She still shows a pronounced tremor of the fingers. There are no definite social adjustments and plans made at present, but the social worker expects to make them in the near future.

Mrs. Angelo is to return to the dispensary for follow-up clinic on December 5, 1928.

References:
Patient's chart
Dispensary record
Social worker

References on Disease:
Principles and Practice of Medicine, Osler
A Manual of the Practice of Medicine, Stevens
Textbook of Materia Medica, Blumgarten

The Patient[1]

HERMANN VON W. SCHULTE, M.D.

TO speak of the patient is to speak of the center and object of our professional work. Yet so many technics have been invented, so many procedures developed in his behalf, and we doctors and nurses become so absorbed in them, that the patient in our hospitals may at times have some cause to feel that, like a bridegroom at a wedding, he is little more than an adjunct to the situation.

The concept of the patient is an index of the state of contemporaneous medicine and more intimately of the level of development of its practitioners. The view, more often acted upon than expressed, that the patient is the container of a diseased organ, and will return to full health on its removal, inadequate and superficial as it is, has not wholly disappeared today. It lingers among the worst surgeons and the worst surgical nurses. Real progress is made when it is recognised that disease, however conspicuous are its focal symptoms, affects the whole body, exerting some effect on all its processes. The patient enlarges from a diseased organ to a sick organism. Nor is that all; to himself at least our patient appears to be a

[1]Given at the annual meeting of the Nebraska State Nurses' Association and State League of Nursing Education, October 18, 1929.

person. To the poor, painful, tender body we must add the thought of an anxious fearful mind, conscious of family, business and social relations and apprehensive of the immediate and remote effects of the illness.

To designate this complex of interacting mental, physical, and social relations as the "case of gallstones in Room 23" would seem, to put it mildly, evidence of intellectual limitation and emotional bankruptcy. Of course we do not think actually as crudely as such loose talk implies. But there is history behind the misleading phrase. It reverts to the early days of scientific medicine when, under the stimulus of German laboratory methods, interest centered for a time on the disease so intently that for some investigators the patient receded into the background. I recall an example of this from student days. A very eminent professor, a celebrated student of pathology, was presenting a patient to the class. He gazed at him dejectedly and exclaimed, "Unfortunately, gentlemen, these cases do not die; it would be most interesting to have specimens of these organs." The laughter of the patient and the amusement of the class brought him to a shocked recognition of his defective bedside manners. Yet when we carelessly say "a case" we are thinking in terms of such dehumanized mentality.

We are on safer ground if we school ourselves to remember the meaning of the word "patient"; it is derived from a Latin root which means to suffer. We may well, especially today, recall the words of an ancient English prayer and recognize in our patient one who "suffers in mind, body and estate."

And the patient who traditionally suffers from many physicians and nurses has much to endure from family and friends before he escapes to a hospital, or takes refuge with the cold detached professionalism of doctor and nurse.

He becomes a center of interest to his circle, a favorite topic of neighborly discussion. He has, let us say, a pain in the right upper quadrant and is secretly worried about his gallbladder. Old Mrs. Jones remembers her husband had a pain in his left side and Dr. Smith prescribed a liniment. She thinks she knows what was in it and, even though her husband died, Dr. Smith was so kind, not like the doctors of today who only want to operate, and nurses who spill medicine on linen and furniture, and so on and so on.

He soon discovers that he has always been under closer observation than he supposed. All his little personal ways and habits have been scrutinized and far from always approved. Of course he has a pain, what should he expect with his coffee drinking, his nap after luncheon, those cigarettes which inhaled into his kidneys have corroded his bile ducts! The wages of sin are due from one who has so departed from the way of rigid Puritanism. Thus must he suffer in the house of his friends.

Often the suggestions are ghastly. I remember a lady who visited in the hospital where I was an interne to give such patients an opportunity to improve their moral state. She had a tract which I got one day after one of my favorite patients had an attack of hysterics. It described a godless man who had gone to the hospital very sick. As a small boy he had been wayward and did not say his prayers, and now he was lying there speechless but unrepentent. Too weak to answer, he still could understand when they said, "What a nice autopsy he will make!" He tried to tell them he was not ready, but his tongue would not move. Then the tract cut loose from all

restraint and horribly described the morgue, the gruesome preparations for the autopsy, and the transfer of the living sinner to the table. Just as they were pressing that awful knife into his throat he became able to pray. His tongue was freed immediately, his life was saved, he convalesced, recovered and became a missionary!

The average patient has been unnecessarily harassed in the environment from which he comes to our institutions and has been prejudiced against the environment he is about to enter. Some deep trend in human nature prompts us to take it out in one way or another on our friends when they are out of luck, and we rejoice in the opportunity to force our meddlesome ignorance upon them when they are least able to defend themselves. And so our patient enters the hospital with fear, has peculiar ideas about what it is like, wonders if the doctor will operate just for fun, and thinks the nurses are there to get thrills out of his sufferings. Once I saw a group in front of the operating theatre of a large hospital. One man pointed to its designation, "The ——— Operating Theatre," and I heard him say as I passed, "Pain is a spectacle to them." That is the unfortunate attitude of some people still: the patient suffers.

A sick man is not supposed to be reasonable. The very processes that have made him sick have had their effect upon his mental reactions. He is not at his best from the standpoint of judgment. His will and self-control are weakened and his emotions have more play. He is more suggestible than he would be in health. This means that he is more disposed to receive ideas without criticism and to accept them as authoritative because of their source without examination or sober reflection.

Suggestibility has its social advantages. It would be difficult to teach children if they would not accept ideas on authority. If we were all "from Missouri" the teacher's life would be more difficult even than it is today. So would the nurse's. "Drink that. It will make you feel better," and the draught is swallowed.

I recall a patient who entered the hospital with a fatigue neurosis and a mild bromid habit. She wished to be assured she should have plenty of bromid. The promise was given. The first night she had a larger dose than she was accustomed to and slept well. After that she slept soundly on salt and water. The suggestion was effective. If she had been told that she could not have her bromid there would have been a wakeful night—suggestion again. Your patient will take your suggestions in a great many ways, not always as you expect. That is one reason why nursing is so difficult.

You are a large part of the environment of the shut-in during his waking hours. There must be a good deal of conversation. You will talk to entertain, amuse, and divert him. Sometimes the things you say produce worse effects than you have any idea of. It is easy for a nurse or a doctor to talk the commonplace jargon of the hospital, which has a horrifying sound to the patient. You are telling about an "interesting operation" you witnessed, but the patient does not sleep that night. He has taken it home and imagines that is what is in store for him, and is disturbed about it. A great deal of what seems without emotional load to us is heavily loaded for some of our patients.

How can you put a patient in the hospital and keep him out of its atmosphere? The institution suggests things disturbing to the laity. Though they pass through the hospital

to health, it is a terrifying portal. The professional preoccupations of doctor and nurse are sometimes anything but soothing to a frightened patient. It is hard to realise that that big man scolding from his bed is really frightened. Likely enough, he blusters to keep up his courage.

The majority of patients are afraid of a great many things that perhaps they will not talk to you about. They are afraid of the pain they have, and what they may have to go through in order to get a cure. They are afraid of the effect of their illness upon themselves. "Shall I get well? Shall I get entirely well or shall I be partially disabled? How long is it going to take? What does it signify to me? Will I be a sound man, or must I change my occupation?" Such things are passing through his mind when you want him to eat his spinach, or have his temperature taken, or turn over and go to sleep and not ring the bell any oftener than he has to.

He is in an institution which has customs which amount to rules, and it is taken for granted he will fall in with them. He usually does, but does not like it very much. He has little personal habits which do not fit in with the hospital régime. It irritates him a little bit.

The nurse is so cheerful about everything she does, it is sometimes exasperating. If you can remember having one of your ears washed and getting a slap on the other one and the remark that "It doesn't hurt," you are in the position of the patient who does not like to be handled in the way you are doing it. Personally I think it is difficult to be manipulated by another person. I think most of us intensely dislike it, and submit to it with such grace as we can. To have the other person so cheerful over what is uncomfortable to us is vexing. Few things are more exasperating than to have the nurse come in thirty minutes after one has rung, and say, "Good morning! I know you rang, but there are other patients here besides yourself." It was an injury to make you wait. Not to be sorry is worse. It is better to take the salesman's attitude that the patient is right rather than to try to explain just what portion of a million dollar hospital he has hired at twenty-five dollars a week.

Emotions are physical as well as mental states. When you are angry or frightened or suffering it is not purely something going through your mind. Definite things are happening in your body—more sugar in the blood, more tone in the muscles, an increased restlessness of the whole body, and so on. Emotions are hard to manage and add to the difficulties of nursing. We want emotions to help rather than to impede progress. If the patient is obstinate, frightened, or suspicious, his emotional state counts against him. If he is acquiescent, coöperative, and courageous, then his emotional reactions aid him along the way you want him to travel and make the journey happier.

Mental suffering is as real as physical. In sickness rest for the mind is important, in the same way as it is important for the body. For one as for the other a technic can be acquired. Here the nurse can do much. At times she counts for more than the doctor, for good or ill, for she is there all the time. If you do not like the doctor, at most you only see him at intervals. If your nurse gets on your nerves you are in a wretched plight.

It is necessary to study the patient and learn as much as we can about his mental and emotional make-up, his educational and intellectual background, and ascertain what you have

to keep house with in that mind; and then make it as neat a piece of mental hygiene as you possibly can. I fear it will be looked upon as one of the signal failures of medicine in this generation that the average neurotic patient is not helped more than he is. He ought not to be dismissed as a neuro. We continue to charge for our time, but we dismiss our responsibility. Such a patient is suffering and needs care. If we are not willing to learn to give the care such patients need, let us have the decency to refer them to others. Let us not take their money and give nothing in return. It hurts the profession, and today does more, almost, than anything else to promote quackery—this failure to understand cases in which the reaction, emotionally and mentally, seems out of proportion to the physical symptoms that can be discovered.

There are three general attitudes about this whole matter of sickness: there is our professional attitude, which is asking increasingly that laboratory methods shall be carried to the bedside; there is the attitude of the public, which wants health without making adequate provision for its protection; there is the patient, who wants to get through his trouble without meeting its cost. I do believe the idea is growing that one ought not to pay for being sick. It is bad enough to be sick.

You must realize that there is more complaint against medicine and the allied professions on account of cost than any other one of our shortcomings. The cost is hardly our shortcoming. It has unavoidably increased. Consider the number of delicate tests made to secure a diagnosis, the complicated technic of the therapeutic agents and agencies used, and add to these the diagnosis of the psychologists which I have been talking about, and the diagnosis of the social worker who will follow our patient out from the hospital and adjust him to his environment and you will realize all these cannot be paid for out of the sacrifices of the nurse or doctor or hospital. Money must be found in some other way.

It is highly worth while for us to think of the cost of sickness. It affects our patient's attitude towards us, and his mental reaction to illness, and alters our opportunity of serving him. It is our duty to render our service as efficient as possible—in other words, to solve the problem, as far as we can, of how few doctors and nurses can keep America healthy, not how many can get a living in the United States. Our professions are for the service of the public. We are rendering dis-service if we tolerate conditions in which two do the work of one.

We cannot work efficiently in groups without organization. According to the seriousness with which we undertake to eradicate disease, will be the extent of this organization. If we become actually health-minded, I do not see how we can stop short of national organization.

Some methods must be devised to spread the cost. The one usually thought of is insurance. If we go into widespread insurance with the state or with private companies, sooner or later both nurse and doctor will become the agents of these companies and will work, not independently, but more like officers or employes. If we must accept this status or even go into state medicine to serve our patients more completely, let us do so advisedly, prompted by the high traditions of our callings, not heedlessly, not driven, but with a definite program vindicating our fitness to lead in the vital matters entrusted to our professions.

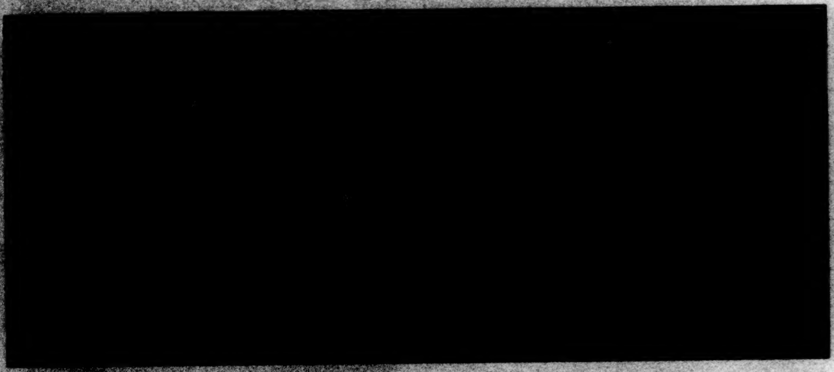
Practical Suggestions from Three Children's Hospitals

Collecting Specimens of Urine from Infants

Harriet Lane Home for Invalid Children, Johns Hopkins Hospital

MARGARET INGERSOLL, R.N.

The Single Specimen



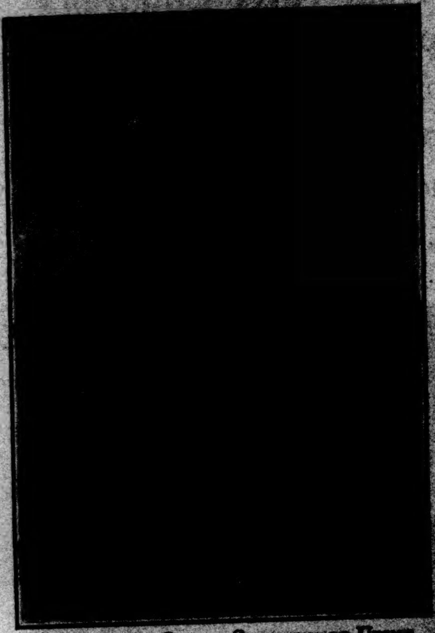
Equipment for Single Specimen

2 restrainers, 1 specimen binder, 1 specimen bottle, 1 test tube, 7 safety pins

THE collection of a urine specimen from a girl or boy baby presents many problems. The child may be restless and too young to coöperate by voiding at a given time. The most practical, durable equipment, that is quickly and easily adjusted with the least discomfort to the patient, consists of two muslin restrainers, one specimen binder, a test tube and seven safety pins.

The restrainers are made of two thicknesses of muslin, measuring 25¾ inches by 5¼ inches, stitched together. Two small double tabs, measuring 7¼ by 2½ inches, are stitched 6¾ inches from each end, or 12 inches apart. At each end three double strips of ½-inch tape, 10 inches long, are sewed. These are to be tied to the springs of the crib. One restrainer is placed across the bed on a line with the child's ankles; the other is placed under his body to restrain his hands lying comfortably at his sides. The child often falls asleep when in restrainers, and does not feel frightened.

The specimen binder is made of two thicknesses of muslin, cut 24 inches long by 4 inches wide. The upper edge is straight, and the lower edge is cut to make a band 2 inches wide for 14 inches from one end and 7 inches from the other end. The piece remaining is cut so as to be 4 inches wide and 3 inches across. This is to go over the symphysis pubis. The small strips left from the 14 inches are cut into two pieces, 1 inch wide,



COLLECTING SINGLE SPECIMEN OF URINE

folded crosswise and stitched. These strips are stitched 1¼ inches apart at the lower edge of the tab. A hole is made in this tab large enough to hold a flanged test tube. The hole is bound with buttonhole stitch. These measurements allow for ¼-inch seams.

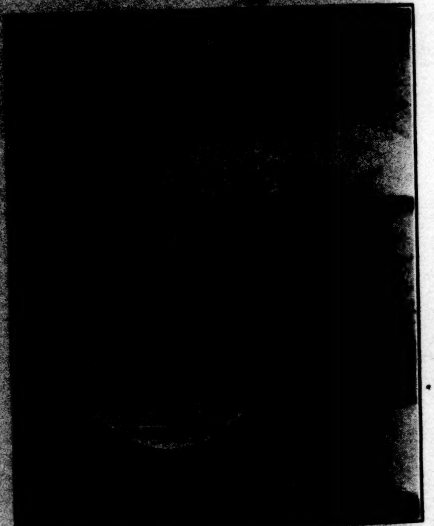
The binder is adjusted around the lower abdomen, so that the meatus of the girl baby is covered by the opening of the tube, or to admit the penis of the boy baby.

The two narrow bands go under the groin and pin to the main band at the sides. This helps to keep the tube in position.

The Total Specimen

The total specimen of urine is readily obtained from the male infant by using the above equipment, substituting the glass specimen tube and 36 inches of rubber tubing for the test tube. The rubber tubing is attached to the glass specimen tube, and the other end is placed in a specimen bottle. The bottle, covered with a dressing towel, is tied to the bed frame.

Where the bed construction will permit, the springs are slanted slightly to the foot so as to facilitate the flow of urine in the tubing. Where this is not possible, a pillow may be placed under the child's back to aid in the downward flow of the specimen.



COLLECTING TOTAL SPECIMEN OF URINE

A Cloth Holder for Goggle Lenses

Children's Orthopedic Hospital, Seattle, Wash.

ALTHEA M. WILSON, R.N.

DURING the past year we have used sun visors, patterned after the visor on the market, and made of plain colored gingham. They have been very satisfactory, in that they are more sanitary, being washable, and are much less expensive than the ordinary sun visor. The visors are starched well when laundered, so as to retain their shape.

Another article which has been valuable is the cloth goggle holder used to protect the children's eyes when they are given light treatments.

A Holder for Goggle Lenses

The holder is of muslin and made according to the following directions: The strip, doubled, is 4 by 23⅛ inches. The openings on the upper edge in which to slide the lenses are 2⅔ inches wide. The circular openings are 1½ inches in diameter. The lenses must be mounted in the metal rim to avoid burning the patient.

A Simple Method for Cleansing Diapers

The Children's Hospital, Cincinnati, Ohio

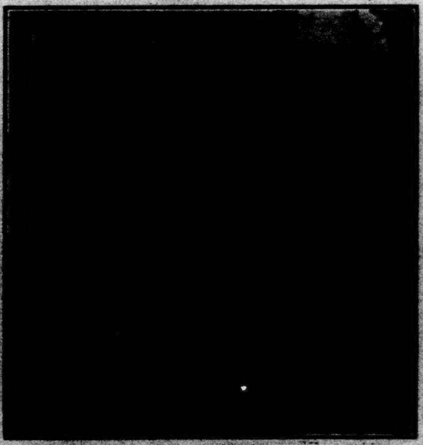
M. CORINNE BANCROFT, R.N.

THE square diaper is coming into more general use, probably because of its many advantages. It is far more comfortable for the baby because there is no extra bulk to be disposed of. It is much easier to care for because all the soil is deposited in one spot.

A practical method for cleansing the diaper is shown by the accompanying photograph.

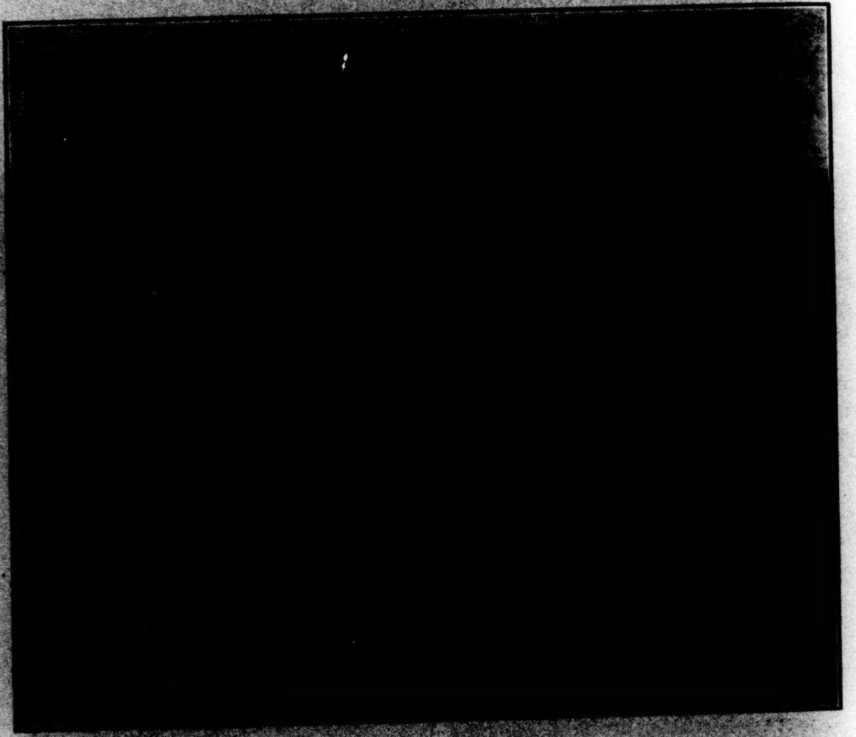
The hose attachment from the hopper allows a stream of water to play over the diaper with enough force to thoroughly cleanse it from feces.

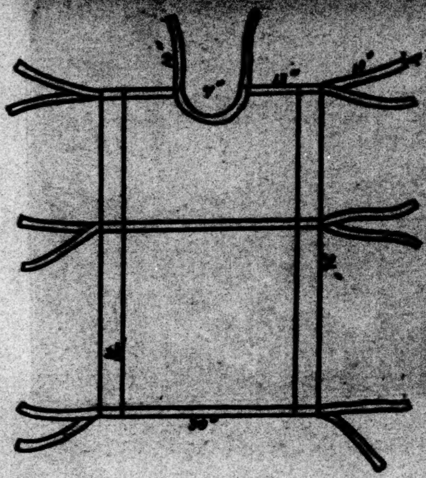
The hopper is situated near a window, so that plenty of light is afforded for examining the specimen.



Protecting Head and Eyes When Giving Heliotherapy

Children's Hospital, Cincinnati, Ohio





IN giving heliotherapy treatment to the infant, the protection of his eyes and head is one of the problems we encounter.

This has been successfully cared for, as shown in the above picture.

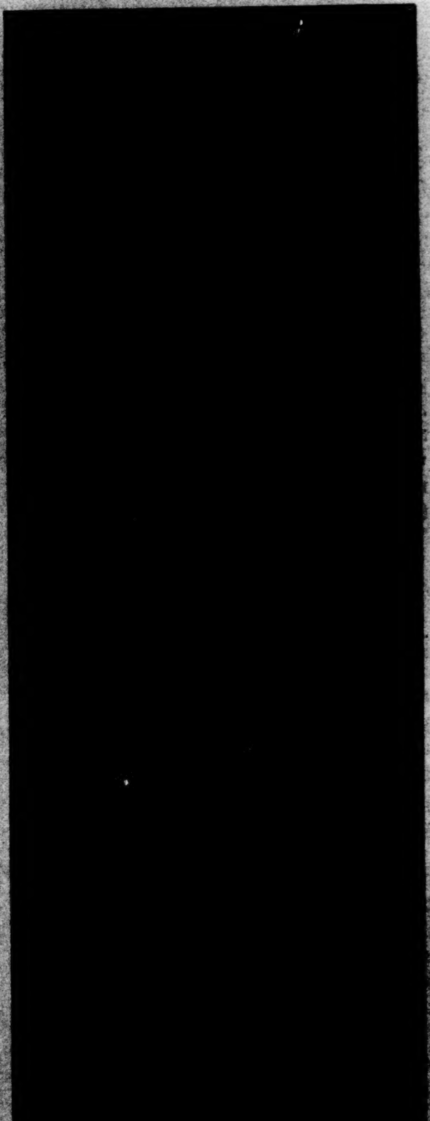
The cut-out at the neck allows ample space for turning the child so that exposure can be made either anteriorly or posteriorly.

This protector could be made of any opaque material. The above is of black, washable sateen, and is fastened to the bed by tapes. The dimensions are given in the drawing.

A Cover for an Ice Collar

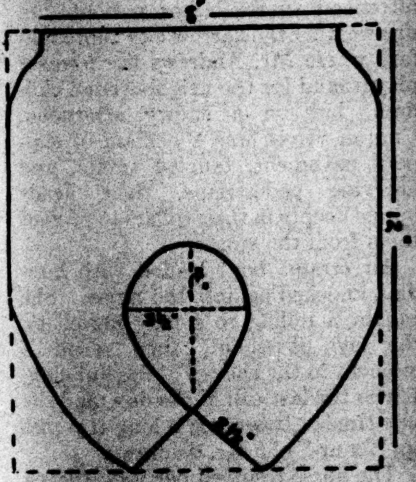
Harriet Lane Home for Invalid Children, Johns Hopkins Hospital

CRYSTAL J. CALDWELL, R.N.



HOW often have you been hampered by trying to stretch a wholly inadequate and fraying piece of gauze over a bulging ice collar? And how quickly has the gauze become wet and uncomfortable to the patient! And, furthermore, how seldom could it be used a second time, and what a considerable waste of material resulted.

A circular ice collar and a single cover which is easily laundered and adjusted is shown at the right. The cover is made of absorbent toweling or canton flannel. The material is cut on the bias so as to aid in fitting the curve of the collar. The opening is finished by a quarter-inch hem, which is used for a draw string of narrow tape. The pattern is shown below.



PATTERN

The Nurse and the Public*

II—Nursing is News

VIRGINIA McCORMICK

"There lies the whole secret of publicity. It is the art, not merely of making, but of being news."—E. L. Bernays.

There are two indisputable inferences regarding the relationship between the nursing profession and the public. The first is that the public, as the consumer of nursing, has the right to know such facts about nursing as are directly pertinent to the layman.

The second conclusion is that nursing has reached that point in its development where it is ready, through official groups, to tell its story to the public. Immediately, however, there arises a question in the minds of many nurses. Is nursing news? What is there to say about nursing? There is no news in a district meeting, nothing spectacular in nursing an appendectomy.

No Nose for News

The nurses who frame this mental query are the same nurses who invariably answer every publicity request with the phrase, "I have nothing to say." Often the nurse is prompted to this reticence by the tradition for silence which is part of her ethical code. Often she is prompted by an inherent distaste for publicity.

Frequently, however, the nurse is quite sincere in this statement. She has nothing to say. She has been so busy training her feet for their thousands of daily steps, and training her hands for skilful ministry, and training her eyes to perpetual vigilance, and her mind to the direction and control of her work, that she has not—to use the phrase—"trained her nose for news." Nurses are living in a world of news, but they do not see it because they have neither the time nor the desire to consider the matter.

The Human Element

How many times, in reading reports of nursing in distant places, have we not yearned for just one story of how a nurse gave a bush baby its first bath, or of how a nurse strapped on her snowshoes and covered the miles of drifts that lay between her and a pneumonia patient. How often we have wished that the registry report would interpret its list of figures by telling, perhaps, of how the hourly nurse brought comfort to the last weeks of old Mr. Andrews.

Picture that nurse, for instance, plodding through a dark, February afternoon to reach her patient. In dry weather the narrow city thoroughfare where Mr. Andrews lived was a playground for the neighborhood children, but on a snowy afternoon, Clinton Street was a bedlam of slippery pavement, tangled traffic, and hurrying pedestrians, their heads buried deeply in their collars to protect them from the storm.

An errand boy, loaded with bundles, knocked against the nurse. She caught a railing to steady herself on the icy pavement, then stood a moment in the shelter of the building. It was the last call of the day, and she was tired. It seemed a long trip just to "fix up" old Mr. Andrews.

The nurse resumed her way, turned into the apartment house where her patient lived, shook the snow from her shoulders, and rang the bell. The door was opened by a little old lady.

"Oh, Nurse," she said, "I'm so glad you have come. Mr. Andrews has been watching for you. He says you are the bright spot in his day. He's asleep now, I think," she added, as she led the way to the big chair by the window.

The nurse tiptoed over to the chair, then bent closer to look fixedly at its still occupant. A wave of thankfulness passed over her that she had come through the storm that afternoon. For old Mr. Andrews would not waken from his quiet sleep and, in her first moments of loss, the little old lady would need the nurse close at hand.

Just an episode? Of course it is. But it is that kind of little story that pictures the entire service for the reader and tells far more than can all the figures in an annual report. And the story is true to the best traditions in nursing for, you will note, the nurse remains anonymous. She is just any nurse doing hourly work. It is what she did that counts in the story.

Straight News Story

THESE reports of registry, district, state group, have real news value, but not as they usually appear, a page or two bristling with figures. There are innumerable stories hidden away in annual reports. What about a story from the district of how the nurses continue their education through the district programs? Or a story of how the nurses in training will have a new classroom, and why that classroom is of importance to the public because it is where the student receives instruction?

Nursing is News

NURSING is news. It contains those three essential requisites of news: It is full to the brim with human interest. There are frequent happenings in nursing of real interest to the public because they affect the public. And news of the nursing profession is of value because nursing exists for public service. Constructive developments in nursing constitute specific contributions to the life of the generation.

Public Information

THE Oxford Dictionary defines *News* as *fresh events reported, new information.* It is the disseminating of new information about nursing, then, that constitutes the profession's responsibility in telling its story. And since this story is directed to the public because of the public's right to know that story, nursing news resolves itself into new information for the public or, briefly, *public information.*

At Headquarters of the American Nurses' Association, a public information service is being evolved, the work of the Publicity Secretary being directed largely along those lines. In newspaper and magazine stories, on the radio, and in talks to the laity, the information given out about nursing is that which the public should know for its own protection.

Objective and Questions

IF public information, then, is our objective in nursing news, we must ask ourselves: (1) What should the layman know of nurses and nursing? (2) How can he be told? (3) Who shall tell him?

The Layman Needs to Know

THE layman needs to know such facts about nursing as relate themselves to him. If public information about nursing is to have news value, it must be couched in terms of the layman's experience and understanding. The greatest error made by nurses in issuing information is the mistake of telling facts that seem important to

the nurses, rather than facts that are pertinent and therefore important to the public.

Mr. Layman will give only a passing glance at a statement that the local training school now is accredited by the state board of nurse examiners. But he will read a half column or more of a story telling why the fact that the school is accredited means better nursing service for himself and his family.

Facts about a local nursing group which residents of a community should know, in order to guard themselves against unskilled nursing care, are as simple as they are necessary. Of the local hospital and school, every potential patient should be aware (1) whether the training given student nurses is adequate to develop high grade nursing care; (2) whether the patient in the hospital will receive graduate or undergraduate service and whether length of hours and charges for nursing service are compatible with cost of service and type of care given; (3) what facilities are offered by the hospital, through group nursing or similar adjustment, for the patient who does not require continuous nursing service for a twelve-hour or twenty-four-hour day.

The Registry

THE same type of information should be put into the hands of the public concerning the nursing facilities of the community, particularly of his local official registry. In a later article, it is hoped to take up in detail the publicity problems of the registry, but the same principles of public information exist, let it be stated here, for the registry as for the hospital; that is, the public has the right to know the essential facts about nursing service available for its use. And how can the patient be expected to discriminate in favor of a competent nurse when he never has been taught how to distinguish the better-class nurse?

Lack of Fundamental Information

THE majority of persons do not know what requirements they should look for in the nurses who come to their homes, any more than they know what the requisites are for adequate nursing care in the hospital. Certainly there is a large group in every community that has no idea where to turn in an emergency for a nurse. Witness the flourishing condition of innumerable commercial registries, some with high standards, many of them indifferent to the registration requirements of the state.

So fundamental is the lack of information on the part of the public in nursing matters, that it fails to realize that, for its own safety, it must demand a registered nurse and that, to secure such a nurse, it must turn to a registry which carries on its books only nurses registered to practice in the state, and which voluntarily supplies the nurse's credentials of registration to the patient.

It is increasingly evident that (1) the public lacks adequate information of the very fundamentals of nursing as they affect the potential patient; (2) the responsibility for telling a community the facts about nursing which it needs to know for its own protection rests with the nurse leaders of that community; (3) no adequate information can be disseminated in a community unless it be developed as a unified and correlated program of information on the part of the participating nurse groups.

Coöperation and Unified Action

THERE is no surer evidence of the sound development of nursing today than is shown in the marked

tendency toward correlation of activities. There is everywhere being evidenced a desire for analyses of function and a subsequent coöperation in activity. Take, for example, the official registry. In a number of outstanding registries of the country, the governing boards are adopting as their major premise, in evolving policies and programs, the fact that registries are only a part in a community nursing service; that in this service also are hospitals and visiting nurse groups; and that, if there is to be no overlapping or repetition, and if every social stratum in the community is to be reached with nursing care, all the nursing agencies of the community must work in close coöperation.

This sound and significant attitude, if applied to public information, augurs well for an early attack on the prevailing lack of information regarding primary nursing resources and requisites.

And in the State

THE same lack of information, moreover, that marks the attitude of the public toward its local nursing resources, is evidenced also in the broader aspects of nursing. There are few persons indeed who know what kind of nursing law in their state protects them from the danger of nursing by insufficiently trained women. But nursing legislation protects the public. Therefore, the public has the right to know whether the state law furnishes that protection.

Interest stimulated and repeatedly roused in the state nursing laws, interest in those developments of nursing in the state which legitimately are news, interest in some achievement of a state leader—such is public information in the state associations. The contributions made by speakers at state meetings are a valuable source of information, if these are issued to meet the interest of the public rather than of a professional group. The nurse who goes as delegate to a state or national convention often fails to turn into news for her local papers the pith of the convention material. Yet sometimes there are happenings and utterances at conventions which may affect vitally the nursing or the public's attitude toward nursing in a community.

State news, like local information, however, is of benefit only when it is directed, constructive, and on a continuous basis; and the same rules hold, of course, for nursing developments of national scope and, therefore, of national and international interest. It is to be remembered that public information is an investment that returns sevenfold in dividends of interest and coöperation.

The Responsibility

THE responsibility for issuing nursing information to the public rests with those nursing groups immediately concerned. It seems a clear challenge to nurse leaders to add the dissemination of public information to the list of their multiplex activities. For if the program of public information is to be unified and directed, it is upon the official leaders that the burden must rest, the training school and registry executive, the district and state officers, the national executives.

This does not mean, of course, that the training school superintendent must write a newspaper story about her school. But it does mean that the training school superintendent has a direct responsibility to her community in interpreting the resources of her school to those who support that school and whose daughters enter training in that school. And what is true of the training school is true in

relative degree of the registry board, the state association executives, and other leaders of the profession.

To Summarize

NURSING is news because it contains the three necessary factors of news:

1. It is replete with human interest.
2. Events in nursing have legitimate news value.
3. Since nursing exists for public service, developments in nursing constitute real contributions to the life of the time and therefore merit recording.

Public information to be effective must

1. Be in terms of the layman's experience and understanding and therefore of interest to him.
2. Be specific, helpful, informative.
3. Be part of a continuous program of information to the public, a program designed to give to the layman those facts for his own information or protection which he needs to know about nursing in his community and his state as well as on a national basis. Haphazard publicity is of no benefit to anyone.

The responsibility for the issuance of nursing news rests with the nurse leaders involved. If it concerns community nursing assets, the responsibility is equally divided among the various nurse groups engaged in nursing the community. If it is of national import, the national organization is responsible for making the news public. And so with the district, state, and other intermediate groups.

[In the March issue of the *Journal* Miss McCormick's article will take up specific problems in public information, stressing newspaper and magazine publicity. Subjects to be discussed in later issues will be "Other Publicity Media"; "Information Concerning Community Nursing Assets"; "Registry Publicity" and "The Task of the Individual Nurse."—EDITOR.]

Here Is What the Director of One School of Nursing, Who is Also President of One of Our Associations, Did with the January Journal.

1. Had copies sent to two persons who had complained bitterly about the cost of private nursing.

2. Wrote to the mental hospital to which her school is affiliated, calling attention to Miss Townsend's article "Two Representative Cases."

3. Called the attention of the Registry Committee to Miss Muckley's article on the Minneapolis Registry.

4. Used the articles on "Loan Funds and Scholarships" and "Private Duty as Seen by a Layman" at student convocation.

5. Used the data from the same articles in an address before a central school group.

Staff Education

BEGINNING in February, Creighton University, Omaha, Nebraska, offers two courses for nurses "in-service." These are Principles of Teaching and Methods of Supervision as Applied in Nursing Education. Classes are planned for Friday afternoons and Saturday mornings in order that nurses holding positions may take advantage of them.

Registered Nurses' Aviation Association

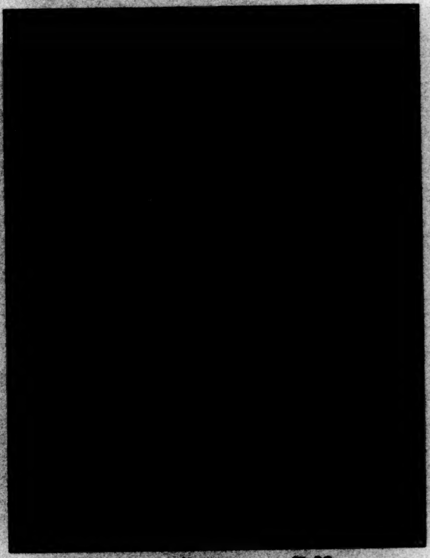
I REALLY appreciate the splendid mention made in the January *Journal* of our organization. The word "nomenclature" to describe what is taught in the twenty lessons may possibly be misleading. I wish to make clear that the introductory fee is $25, yearly dues $6. Membership entitles members to a complete course (elementary) on all principal factors of aviation grouped into twenty intensified lessons covering the Air Commerce Act and Regulations—the activities of the U. S. Government, and our duty as citizens; aircraft, the general construction and design; use and theoretical operation of airplanes, engines, instruments, etc. Lessons in actual flying are given at cost.

LAURA B. E. RICHTER, *President.*

Illinois.

Some Specialists

Jessie L. Stevenson, R.N.



Jessie Stevenson, R.N.
(Photograph by Koehne, Chicago)

JESSIE L. STEVENSON was born in South Dakota, and has a Bachelor of Arts degree from the University of South Dakota. She taught high school English three years before entering the Army School of Nursing in 1918, from which she was transferred to the Presbyterian Hospital School of Nursing, Chicago. While at Presbyterian Hospital, Miss Stevenson did three months of graduate work in the School of Social Service Administration at the University of Chicago.

Miss Stevenson became a member of the staff of the Visiting Nurse Association of Chicago in September, 1922, and was made supervisor of its orthopedic service, generally known as its Infantile Paralysis After-care work, in September, 1923. She had taken the six weeks' special course in Physiotherapy at Harvard Medical School during the summer of 1923. In 1924, Miss Stevenson was given a leave of absence to conduct a survey of cripple children in the city of Chicago. This study was financed by the Rotary Club and was done under the immediate auspices of a special committee appointed by the Chicago Community Trust. Several thousand copies of this Survey have had wide distribution, and it has been useful when similar studies were being made in other cities.

During another leave of absence, in the summer of 1928, Miss Stevenson spent a month visiting hospitals and centers for special work with crippled children in England. At this time she represented the International Society for Crippled Children at the Conference of Social Work in Paris in July.

Miss Stevenson is an unusual teacher of her subject and has prepared many nurses who are doing excellent work in this highly specialized field. When the Visiting Nurse Association of Chicago puts special nurses into this field, Miss Stevenson prepares them with a special outline of class demonstrations and practical work in anatomy, massage, muscle examinations,

etc. This preliminary preparation requires from six weeks to two months. In so far as it is possible to do so, the Association starts three nurses at a time and its ambition is to have, in each one of its eleven outlying substations, a nurse who has had this special preparation with Miss Stevenson and not less than one or two years of field work with her. To date, however, the nurses who have had this work are so much in demand that the Association can hardly plan for its own vacation substitutes.

The work was started as an aftermath of the big poliomyelitis epidemic in 1916. Now that it has been learned that muscle reëducation can be used for all sorts and conditions of disfunction, it is impossible to continue the work throughout the entire year without vacation substitutes, for more than half of the patients are fracture cases or their treatments include the correction or prevention of deformities due to burns, sepsis, accident and many other conditions. A number of nurses from other organizations have spent special time with Miss Stevenson in order that they might receive this training and preparation.

Miss Stevenson is on the Editorial Board of the *Public Health Nurse*. She is also an instructor in the Course on Physiotherapy at Northwestern University Medical School and is a regular lecturer before the student groups in the Visiting Nurse Association. She has been on the national program of the International Society for Crippled Children and on programs of various state association meetings of graduate nurses, and is in demand for local meetings in Chicago. Just now she is President of the Physiotherapy Club of Chicago, in addition to her present work. In 1927, she was Third Vice President of the First District Association of the Illinois State Association of Graduate Nurses.

In addition to her Survey, Miss Stevenson is the author of several articles which, in the original and in reprint form, have been widely used. The best known are: "The Prevention of Deformity," the *American Journal of Nursing*, July, 1927; "The Infantiles," the *Public Health Nurse*, July, 1929; and "Physiotherapy as a Part of the Nursing Curriculum," the *Modern Hospital*, October, 1929.

The Public Health Nurse for February

Official Magazine of the National Organization for Public Health Nursing

(*May be had in combination with the Journal*)

Problems in Rural Social and Health Work—Dwight Sanderson.

Orthopedic Nursing in the Minneapolis Visiting Nurse Association—Elma Harrison.

Service Norms and Their Variation—Emma A. Winslow, Ph.D.

Among the Negroes in Southern Maryland—Myrtle M. Patten.

Alabama's Health Program—Jessie L. Marriner.

Iodin and the Thyroid Gland—Martha Koehne, Ph.D.

Rural Hospitals as Health Centers—Mary K. Nelson.

Interrelationship of Visiting Nurse and Hospital.

The Effect of Prenatal Care upon the Infant—Clifford G. Grulee, M.D.

Projects in Staff Education.

A Suggestive Efficiency Scale.

When Your Children Have Measles, Don't Keep Them in the Dark—B. Franklin Royer, M.D.

Scholarships, Loan Funds and Leaves of Absence.

Editorials

Nation-wide Returns on Grading

RESTLESS folk, who have felt that the Committee on Grading Nursing Schools was not demonstrating work on actual grading, will be relieved to see the data released from the office of the Committee in "The Educational Background of 63,000 Students" on page 162. The labor of accurately compiling such statistics is enormous. Their value will be determined by the use made of them by state boards of nurse examiners and by all others concerned with nursing education.

In high school preparation for nursing, Nebraska leads! This despite the fact that some states have a higher legal requirement than Nebraska. Probably the Nebraska Board is the only one of the forty-nine which will not be surprised at this result, for each will recall its own strenuous efforts to establish a really sound entrance requirement. What are the significant factors in Nebraska's success on this point? The fact that it has a relatively small number of schools will not serve as an alibi for larger states. All are subject to certain general influences such as the requirements of four years of high school made by the Veterans' Bureau Nursing Service, with its fifty hospitals, or by most of the visiting nurse associations. To find the answer it is necessary to study not only Nebraska but the other states.

There has been a tremendous increase in the enrollment in public high schools throughout the country in recent years. To be exact, it rose from 2,199,389 in 1920 to 3,650,903 in 1925. In Catholic high schools it increased from 74,538 in 1915 to 204,815 in 1926, an increase of 174.8 per cent. In Nebraska, there was an increase of 92.8 per cent between 1920 and 1926, but—twelve states did even better. Of these states, Florida stands at the top. It must be borne in mind that these figures are for enrollment, not for the completion of the course. They are none the less significant. Have schools of nursing been a little slow to appreciate this extraordinary change in public sentiment regarding education? Were the schools in Nebraska unusually fortunate or unusually alert in sensing the change and in reaching up toward a desirable standard?

Children in Massachusetts, Utah, New Jersey and Maine remain in public schools longer than those in other states. As one writer puts it, these states "have definitely gotten out of the grammar school." Yet, of the four, only in Maine does this tendency reflect itself in the ranking of schools of nursing on this one point.

Comparative data have value only if wisely used. Probably the nurses of every state will feel that it is important to know the factors entering into their rank, whether high or low. Are the variations between states due to fundamental differences in the states themselves, to political conditions, to the quality of professional leadership, to the methods employed by legislative committees, or to the preparation of the members and the methods adopted by state boards of nurse examiners? These, and other questions,

need answering in each state for it is very certain that such things do not just happen. "There's a reason."

In general, it may be said that the Grading Committee is endeavoring to find out these things: (1) Are the students teachable, (2) are the faculties competent to teach, and (3) are the patients who are observed and cared for by student nurses well nursed?

As the studies of the Committee go on, interest will mount ever higher, until all returns are available. At the moment we are wondering which state will stand first in the next ranking, whatever that may be.

The Cost of Medical Care

SIXTY senior and one hundred and fifteen affiliated students recently have had the rare privilege of a thirty-hour course with Miss Clayton, President of the American Nurses' Association, in which they have discussed many important professional problems, including economic problems of nurses and patients. The fortunate young women are, of course, Miss Clayton's own students in the Philadelphia General Hospital School of Nursing. "At just the right moment," says Miss Clayton, "we received the January *Survey Graphic*." This number, which is devoted to "Adequate Medical Care for Everyman," was assigned for special digests and reports.

The *Survey* is available in many schools of nursing. Many other alert principals will already have done just what Miss Clayton has done. Many more will, we believe, be glad to be reminded of this collection of extraordinarily interesting material. Dr. Haven Emerson, in introducing the subject, says:

> The perfect alibi will never be found for health. However loudly we shout Public Health from the housetops, it is our own personal health we are concerned with, and we can no more attain it by hiring a health officer or buying Christmas seals than we can heal a broken bone by proxy, or engage a civil service superintendent of hospitals to have our attack of appendicitis for us.

Beginning then with the immediate and personal point of view, the subject is discussed from many angles by exceedingly well qualified persons. In "The High Cost of Nursing," Janet M. Geister has vividly and convincingly surveyed the situation. Miss Geister, as most nurses know, believes that many persons are doing without nursing which would "contribute to their comfort, security and early recovery. We believe, too, that many patients dismiss their nurses sooner than they should because of cost, and try to manage without their care through the difficult days of convalescence." She closes her article with a plea for a broad gauge "experiment in nursing a whole community, financed by the community."

This is well capped, so far as medicine is concerned, by Dr. Ray Lyman Wilbur, writing of the task of the Committee on the Cost of Medical Care, of which he is chairman, when he says:

> The fundamental cause of our present difficulty, in so far as the medical profession and the majority of the population is concerned, is that we are still mentally viewing medicine from the standpoint of the days when the doctor and his saddlebag provided all that medical science could bring to the bedside of the typhoid case, or the mother undergoing the pangs of childbirth.

And so it is with nursing. As we said in a January editorial, many nurses and lay people are still thinking in the style of the nineties, so far as nursing service is concerned. The laity will never do much about changing "styles" unless nurses guide them. It is not only the public, but large groups of nurses themselves who need

the stimulation of Miss Geister's forward-looking article. Thanks to the leadership of women like Miss Clayton, in some of our schools, not only the graduates, but also the nurses of tomorrow are being taught to take the larger view.

Leadership

NURSING has more than once been complimented by representatives of other groups on the quality of its leaders. The names of many of those we love to honor are known and loved wherever American nurses are. What made them leaders? Was it knowledge, vision, courage, persistence? Was it personality? Was it a capacity for hard self-sacrificing work? Was it good judgment—the gift of seeing the relative importance of programs, of people, of things, of activities? Was it the ability to carry an idea, like a torch, until it had illumined the dark places? No two are alike. Some qualities predominate in one, some in another. Some became leaders because opportunity arose. Some would have been leaders in any vocation they might have chosen. Zeal, enthusiasm, and loyalty to certain ideals characterise them all.

Leaders are of two kinds, those who aid their associates to attain their fullest stature in order that they may carry on, and those who permit about them no personalities which would tend, by contrast, to dim their own luster. Nursing is fortunate in having many of the first type.

No group can exist without leaders. Fortunately, there is ample opportunity in nursing for the development of those who have the potential qualities of leadership. In the alumnae associations, in the district, and in the state associations, there are today the young women who must inevitably be the nationally and internationally known nurses tomorrow.

Nominating committees and voting bodies have a responsibility to the profession which they do not always recognize. Theirs is not merely a responsibility for filling offices. They are responsible for the quality of the leadership in the group. Personal likes and dislikes, petty prejudices, the poisonous trail of partisan politics should not be allowed to becloud the issue. It is not an act of friendship to place an individual in a position for which she is unfitted as a reward for useful service elsewhere. There is real danger of detracting from the prestige established, in one field, if the individual cannot measure up to the new responsibility, and there is grave disloyalty to the organization or the activity which must mark time until a new election puts a competent person in the office. In the main, we believe that our organizations are singularly free from self-seeking politicians. It is unfortunate that there should be any exceptions to this rule. The fact remains, that real progress is sometimes blocked by the selection of the weak, or biased, or unqualified persons for important posts. Choices cannot always be wise. Individuals will not always develop in ways expected or hoped for. But a basic principle might well be everywhere adopted, namely, find the strongest and best qualified person available for the post to be filled and then, having persuaded her to accept responsibility, support her in every way possible. Make selections on the basis of the greatest good to the greatest number over a considerable period of time. If nursing organizations everywhere accept the responsibility for wise selection and for loyal support of those selected, we need not fear that "*once* they had wise leaders" will ever be said of nursing.

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Ruth Ingram, R.N., B.A., M.A. (Oberlin College and Pennsylvania Hospital School of Nursing and Teachers College, New York City), is something of a globe-trotter. She studied nursing conditions in several European countries en route from China where she was Dean of the School of Nursing at Peking Union Medical College.

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The author of "Trials of a Registrar" is a registered nurse who has had twelve years of experience in a registry serving a mixed urban and rural area.

That Dr. Marion Craig Potter, a practicing physician of Rochester, N. Y., was one of the earliest advocates of sound teaching on social hygiene for nurses is indicated by the articles she prepared for the *Journal* in 1907. She is still doughtily waging warfare against ignorance on the subject.

Elsie M. Paisley, R. N., is a public health nurse, who came upon the interesting story she tells in the ordinary course of her work.

Sister John Gabriel, R.N., B.S., is the brilliant Educational Director of some fifteen schools in the Northwest which are in the hospitals of the Sisters of Charity of Providence. She is author of *Principles of Teaching in Nursing Schools*.

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We are indebted to Edna L. Foley, R.N. (Smith College and the Hartford Hospital School of Nursing), the brilliant director of the Chicago Visiting Nurse Association, for the data on Miss Stevenson. Her college has honored Miss Foley with an honorary Doctor of Science degree.

Helen W. Munson's article on Lesson Planning is based upon her own recent experience in teaching at Teachers College.

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Department of Nursing Education

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Some Suggestions for the Planning of Lessons

HELEN W. MUNSON, R.N.

It sometimes happens that a new member of the teaching staff in a school of nursing is chosen from among the recent graduates because she has shown unusual ability during her "training days," but too often, unfortunately, quite without regard for the fact that in order to teach she needs something more than familiarity with hospital ways and recent additions to medical science and their bearing on nursing methods. While these last are an absolute necessity in the equipment of any teacher in a nursing school, their value to the young and otherwise inexperienced teacher must to a certain extent be offset by her bewilderment in the face of preparing to present this material to her class. It is with this group in mind that these suggestions for planning lessons are made. They are not intended in any way to take the place of further preparation for teaching. They contain nothing that is new and many will recognize the sources of the material presented here.

That lesson planning is not merely a phase of normal school days and practice teaching, to be discarded at once on beginning the serious business of actual teaching, is shown in a study conducted recently among 1,103 elementary and high school teachers. The median teaching experience of this group was 8-9 years. 94.6 per cent of them made the unqualified statement that they planned their lessons. Of these, 61 per cent reported that they were required to plan but, on the other hand, 89.8 per cent said that they would plan if free to do as they chose. Only 1.5 per cent said that they would not plan.[1] These figures seem to demonstrate that teachers in actual practice find values in planning.

In considering these values they resolve themselves into the following: Anything which is thought through beforehand, even if it is only a meal, is apt to be more complete, to have its parts more carefully related, and to be more suited to the tastes and needs of those for whom it is intended. Again, to plan and plan again, makes for a habit of planning which, while it may be irksome at the outset, later gives the teacher far more freedom in the management of her classes.

To make a plan involves, on the teacher's part, careful consideration and a statement of the aims of the lesson, of the procedure to be followed and of the assignment which will connect the present lesson with those to come. Lack of a plan may lead her away from the main topic into some unimportant bypath from which it will be hard to return without much waste of time.

[1] Mossman, L. C., *Changing Conceptions Relative to the Planning of Lessons*, Teachers College, Columbia University, Contributions to Education, No. 147, pp. 43-45.

A plan that is written down safeguards remembering. Even if it is not actually referred to during the class to any great extent, the fact that it is there gives younger teachers a certain assurance which helps to do away with stage fright. Furthermore, years of experience are often necessary before one is able to present materials connectedly or to guide a class through them in an organised way without notes of any kind.

A written plan provides a place in which the teacher may record much information which will be of use later. There is, for example, the illustrative material needed for the lesson, the references for both teacher and student, and the assignment which should follow the lesson. Again, after the lesson is over the teacher may make written comments on the plan as to the amount of time the lesson required; whether the content of the lesson was well planned to fit the time allowed; whether or not it covered the important points of the subject; suggested topics to include in giving the same lesson later; questions and problems brought up by students; and questions formulated by the teacher for use in examination. Perhaps the greatest value of a plan lies in the fact that comparison of the written plan with the lesson she has just taught shows the teacher what she has achieved in a given lesson.

Enriching One's Background

THE knowledge and experience which the graduate nurse possesses is not sufficient preparation for teaching. She must constantly add to her store of these. Collecting subject matter is one of the most interesting parts of teaching and extends over much more time than that required for everyday planning. Once in her subject, almost everything she reads or experiences seems to the teacher to have bearing on it. In addition she goes out of her way to find new materials which will amplify her own knowledge beyond the limits of the textbook. One of the most suggestive articles on this subject appeared in the *American Journal of Nursing*,[2] and is worth re-reading. The *American Journal of Nursing* might well be considered a teaching manual.

The hospital offers far more to classroom teaching than is now used. There are laboratories, pathological specimens and case records which could be called into service oftener than they are. The Hospital Library and Service Bureau of the American Hospital Association[3] offers its resources to "everyone interested in hospital affairs, public health, sanitation and the prevention of disease." Its service includes sending out, without charge, bibliographies and package libraries on a wide variety of subjects, and it should be a splendid source of information to teachers who have not access to a well stocked library. A number of firms dealing in pharmaceutical supplies, several public health agencies and like organisations send out motion picture films covering a number of different subjects. There are also extension, evening, and summer courses and often scholarship and loan funds to make these possible. Some one has said, "You can get anything in the world that you want, provided you want it hard enough."

For a method of organising materials and sources so that they will be at hand when needed, teachers are

[2] Walker, Lena Dixon, "Finding Teaching Material," *American Journal of Nursing*, September, 192[illegible].

[3] Hospital Library and Service Bureau of the American Hospital Association, 18 East Division St., Chicago. Charlotte Jones Garrison, Director.

referred to Ann Doyle's exceedingly helpful article on filing in the *American Journal of Nursing* in 1927.[4]

Lesson Planning

PREPARING for a lesson involves more than the actual writing out of a guide to a given lesson. The plan itself is concrete evidence that this preparation has been made. It involves a number of things.

First of all it is necessary to consider the course as a whole and the aims of the course, and then to divide it according to the large units into which it naturally falls and these into the topics which make up the individual classes. Fortunately the National League of Nursing Education has provided a guide,[5] but in many cases this arrangement of courses will need to be varied to suit individual schools.

It is necessary to plan for individual classes with the aims and arrangement of the whole course in mind. For the most part this planning will need to be done from day to day, since usually what is planned in one lesson must relate closely to what was taught in the class preceding, and each must be so shaped that it contributes to the major aim and plan of the whole course.

The starting point in the daily lesson plan is an expression of the need for that lesson. The teacher is, in a sense, selling the subject to her students. If it is to mean anything to them they must realize their need for it, quite as much as must the housewife her need for the latest electrical device, before it can be sold to her. The need for the particular lesson should be stated as a problem by the teacher as the first step in making her plan. For example, in teaching the lesson on "The Laundry" in the course in Hospital Housekeeping the problem involved in that lesson might be expressed as follows: "What is the relation of the laundry and its function to the care of the sick in the hospital and elsewhere?" This means more than starting the plan with the topic "The Laundry."

It is easier to formulate aims if there is a problem in mind and an aim is necessary if the teacher is to know where her plan will lead and whether she has arrived there. In any lesson there will be several aims and the teacher's aims may differ from those of the students. In the lesson just referred to, the teacher's aim includes "giving the student an understanding of the workings and problems of the hospital laundry so that she may coöperate in making hospital service more efficient in caring for the sick." The student's aim, on the other hand, may include that of, "learning the principles underlying the cleansing of linen and clothing coming in contact with the patient and also the prevention and removal of stains."

The amount of subject matter to be written into a lesson plan depends upon the teacher's familiarity with and experience in the subject which she is teaching. It should be selected in view of the students' needs and organized under several main headings, in order, as it leads from the students' past experience into the new field. Subject matter in great detail on a plan is apt to be confusing and time-consuming. It is well to formulate in advance a few so-called "pivotal" questions dealing with the main headings of subject matter and upon which the discussion can turn. It

[4] Doyle, Ann, "Professional Literature: Finding What You Want When You Want It," *American Journal of Nursing*, November, 1927.

[5] *A Curriculum for Schools of Nursing*, prepared by the Committee on Education of the National League of Nursing Education, 370 Seventh Ave., New York.

would not be helpful or necessary to write down on the plan every question which one might expect to ask. An example of a pivotal question in the lesson on the laundry might be: "What principles of hygiene are involved in changing patients' linen frequently and regularly?" It should not be necessary to go into detail as to the questions which might follow regarding perspiration, body discharges, pressure sores and the like.

A lesson plan should provide for summaries as it proceeds from topic to topic and also at the end. These might be questions or problems to be worked out in the class, or the summary of one lesson might be entirely preparation for the assignment for the next.

A complete list included in the plan of the materials needed for demonstration or illustration will prevent confusion and forgetting at the time of assembling them for class.

The references used by the teacher in preparing her part of the lesson, listed on her plan, will be of great help toward preparing the same lesson another time. References for the student, in detail as to title, author and page, should also be included.

The assignment for the next lesson should be worked out with great care if it is to be of value to the student. Pillsbury says:[4]

> The temporary conditions of observation are mostly found in the questions that the observers ask themselves as they look. If there are no questions, little will be seen. Where the individual looks to obtain an answer to a definite question he will find the answer to that, but may see nothing else. What questions will be in mind at first depend on chance suggestions. They increase and become more appropriate with practice in each situation. This is important in all teaching by the natural observation methods. It is practically useless to present a child with a bit of material of any kind and leave him unaided to find out the essential details. He will spend a long time finding something to look for and then will probably have the wrong question in mind, so that while he obtains the answer to that, he will not be able to answer any of your questions on anything else. To leave him unguided in this connection is a waste of his time and is likely to be a waste of your time also.

In making an assignment then the teacher should so plan that the students know the problem involved and have in mind what it is that they are trying to find out through this assignment.

Form of Plan

PERHAPS the most familiar form of lesson plan is the two column plan with subject matter outlined in one column and the method stated in the other just opposite the subject matter to which it relates. Here are included the "pivotal" questions, the diagrams that are to be used on the blackboard, the reference to illustrative material at the point in the lesson when it is to be used. Cards, paper ruled through the middle vertically, or the two facing pages of a note book may be used. Perhaps it is best for the teacher to experiment and find out the form which best suits her purpose and her system of filing. For, of course, she will keep her plans. After all, the important thing is to have made the plan, to have organized its content and manner of presentation. It is the planning which is important rather than the details of form.

[4] Pillsbury, W. B., *Education as the Psychologist Sees It*, The Macmillan Company, 1926, pp. 144–146.

Bibliography

Strayer, G. D., *Brief Course in Teaching Process*, Macmillan, 1911.
Charters, W. W., *Methods of Teaching*, Row, Peterson Co., Chicago, third edition, 1913.
Douglass, H. R., *Modern High School Teaching*, Houghton, Mifflin Co., 1926.
Mossman, L. C., *Changing Conceptions Relative to the Planning of Lessons*.

Lesson Plan—Hospital Housekeeping and Supplies[7]

TOPIC—LESSON VII, THE LAUNDRY

Class—Preliminary Students

Problem—What is the relation of the laundry and its function to the care of the sick in the hospital or elsewhere?

Teacher's Aim

1. To give the student the principles underlying the cleansing of linen and clothing coming in contact with the patient
2. To give her an understanding of the workings and problems of the hospital laundry sufficient to enable her to coöperate with this and related departments of the hospital in her care of the sick
3. To give her an understanding of the principles underlying the prevention and removal of stains

Student's Aims

1. To understand the steps in the laundry process
2. To learn principles underlying the prevention and removal of stains

Concomitant Learning

1. An attitude of coöperation towards others of the nursing department and other departments
2. Habits of economy in the use of linen and supplies; ingenuity in devising means of saving linen from soil
3. Habits of thought regarding the handling of soiled linen, protecting herself and others

Illustrative Material

Schematic drawing showing position of the laundry in relation to the hospital
Schematic drawing showing plan of laundry
Large drawing of wool and of cotton fibres
Hospital blanket in good condition and one badly shrunken
Stained linen, etc., as with silver nitrate, etc., not more than one or two examples
Materials for demonstrating removal of stain: Stained materials, 2 medicine droppers, 2 glass, 2 bowls, white blotting paper, soft white cloth, soft brush, potassium permanganate, oxalic acid solution, Javel water

References

A. Used by teacher:

Laundering, L. Ray Balderston
Report of the Committee on Laundry Equipment and Supplies
Bulletin No. 49, American Hospital Association
Bulletin No. 49A, American Hospital Association
Selection and Conservation of Textiles, Dept. of Research, Laundryowners' National Association

Bulletin No. 4, *Stains*, Colgate and Co.

B. Assigned to students:

Laundering, Balderston, pp. 2–5, 9–11, Fibres; pp. 12–33, Stains
Selection and Conservation of Textiles, Dept. of Research, Laundryowners' Assn., Mellon Institute of Industrial Research, Pittsburgh
Bulletin No. 4, *Stains*, Colgate and Co., Household Service Bureau, 105 Hudson St., Jersey City, N. J. (Possible to obtain copies for each of class)

Topical Outline

I. *Review*
  A. Importance of having plenty of clean linen
    1. Hygiene of clothing (patients')
    2. Expense

II. *Purpose and Plan of Laundry*
  A. Disposal of soiled linen on the ward
  B. The laundry

III. *Stains*
  A. Classification
  B. Removal
  C. Prevention

IV. *Summary*

V. *Assignment*

Previous Assignment—Estimate the amount of linen required for one bed patient for a week, using as a basis the "Linen Regulations" in use in the hospital. How much would this cost, supposing that it were possible to keep within this allowance? What would be the cost of one day's supply? Would this amount of linen vary in summer and in winter and why? In making estimates assume that soiled linen is sent to the laundry every day and is returned each day following.

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[7] The form of this plan is that worked out in the Department of Nursing Education, Teachers College, Columbia University.

Subject Matter	Method
I. *Review*	I. Discussion of class assignment
A. Importance of having plenty of clean linen available 1. Hygiene of clothing and comfort of patient 2. Expense of daily linen supply for average ward patient This is only one item in the cost of care Need for conservation	A. Why is it good nursing care to change patients' linen frequently and regularly? What principles of hygiene are involved? What is the cost of week's supply of linen? Daily supply?
II. *Purpose and Plan of the Laundry*	II.
A. Disposal of soiled linen on the ward 1. Precautions in handling soiled linen Protect hands—face—other workers—patients 2. Use of laundry bag a. Fill one bag before using another Work of laundry worker is multiplied by having to open many partly filled bags b. Soiled linen always enclosed in a bag c. Reasons against using pillowslip for laundry bag. Effect, when full pillowslip is thrown from a height 3. Importance of sending soiled linen down the chute as early as possible to ensure prompt return of clean linen	A. 1. What precautions is it necessary to take in handling soiled linen? 2. What are some ways in which nurses can coöperate with laundry workers in sending linen to the laundry?
B. *The Laundry* 1. The Plan a. After soiled linen is thrown down the chute (1) Relation of laundry to hospital. Noise—jarring—odors (2) Routing the wash through the laundry	B. 1. a. Schematic drawing on blackboard Diagram on blackboard
2. Purpose of the laundry a. Processes (1) Sorting (2) Cold rinse (a) Removal of blood, pus, food, etc. (3) Washing (a) Hard and soft water (b) Soap i. Chemical action ii. Physical action (c) Temperature of the water	2. a. List on blackboard Compare with home laundry (2) Purpose of cold rinse? Refer back when discussing stains (3) What is meant by hardness of water? (Chemistry, Lesson XII). (b) Lecture, brief

SUBJECT MATTER	METHOD
(4) Rinsing (5) Extracting (6) Tumbling (7) Mangling (8) Folding (9) Sorting (10) Delivery	Lecture, brief
b. Clothing wears out in the laundering rather than in actual use Stress prevention of soil	b. From the discussion which do you think causes greatest wear on linens?
	Trip through laundry at this point Group files through laundry in double file Manager of laundry explains to first half; instructor to second. Large classes will have to be further subdivided 20 students; 30 minutes
c. Some exceptions to the routine process	c.
(1) Linen from infectious patient, sterilized before sending to laundry (Lesson VI, Bacteriology, on Thermic Sterilization precedes.)	(1) How protect laundry worker and others from infected linen?
(a) Blankets ruined by boiling Air in sun before washing, instead	(a) Is it safe to boil all bed clothing? Show shrunken blanket from hospital Drawing of wool and cotton fibre on board Explain shrinking
(b) Special method of washing woolens — blankets, baby socks, etc.	
(c) Effects of boiling on blood stains. Remove first or use other method of disinfection[9]	(c) What will be the effect on blood stains if boiled?
III. *Stains*	III. *Stains*
A. Classification 1. Organic a. Animal b. Vegetable 2. Inorganic a. drugs b. ink c. rust, etc.	A. Write on board stains named by students, classifying: blood, drugs, etc.; pus, egg, etc.
B. Removal	B.
1. Organic	1.
a. Stains of albuminous nature removed by cold water and "set" by heat	a. How remove blood? pus? egg?
	b. What is the composition of these similar substances?

[9] Technic of the care of infectious linen will be taken up later.

SUBJECT MATTER	METHOD
Effect of heat on albumin for instance, egg?	
What rule can be formulated for removing stains due to albuminous substances?	
(1) Cold rinse.	How does the laundry process ensure the removal of these stains which are the commonest in the hospital?
(2) Commercial laundries cannot be depended on to use cold rinse first in every case	What care would you need to take in a home?
b. Fat stains require addition of soap. Saponification	Lecture, brief
(1) Mineral oil and vaseline cannot be removed by ordinary washing	Show oil-stained linen after washing—stain not removed
(2) Precautions when giving treatments requiring oil and vaseline or ointments	Show rubber sheet damaged by oil and the stain it leaves on linen sheet Show pads, etc., in use in hospital for this purpose
c. Fruit stains removed by boiling water	Lecture
2. Inorganic stains	
a. Drugs, medicines, etc.	
b. Common solvents studied in materia medica	
c. Certain drugs cause insoluble stain, as silver nitrate	Show stains
(1) Protection of bed when using this solution as in bladder irrigation	Show types of protection used in hospital
d. Some stains only removed by bleaches	Demonstrate use of potassium permanganate and oxalic acid Demonstrate use of Javel water
(1) Effect of bleaches on life of fabric	Show weakened fabric
C. Prevention:	C.
1. Stains are uneconomical	1. In what ways is it uneconomical to allow linens to become stained?
a. Require linen to be laundered more frequently	
b. Action of certain bleaches shortens life of linens	
c. Time is consumed in removing stains	
2. Methods of preventing stains and other types of soil	What are some ways of preventing soil?
a. bed pads b. "skin linen" c. newspapers as protection for mattress d. etc., etc.	Show as many devices as possible, pads, etc., used in hospital; also those used in homes

SUBJECT MATTER	METHOD
IV. *Summary*	
A. Comfort of patient increased by fresh linen	IV. What points have been covered in this lesson?
B. Linen expense is a large item in the cost of care and efforts should be made to conserve it	Questions
C. Care of soiled linen on the ward	
1. Precautions	
2. Coöperation with laundry workers.	
D. How the laundry process works; cleansing; sterilization	
E. The care of woolens	
F. Stains	
1. A few common stains and principles underlying their removal	
2. Methods of preventing soil	

V. *Assignment* (To be handed in, next class):

What means would you use for protecting the bed of a patient, in a home, who was senile and had incontinence of urine? The family are in very moderate circumstances. Such fresh linen as is available will be washed out by the patient's daughter who has also two children and her husband to care for.

Write out your suggestions.

Be definite in your statements.

References: Outline of procedures in use in hospital.

Maxwell and Pope, *Practical Nursing*.

Look over materials in use in hospital as gauze, crude cotton, etc. an exhibit of which is available in the demonstration room.

Graduate Staff Education

MARGARET A. MOSIMAN, R.N.

THERE have been requirements imposed upon the nursing system which no apprenticeship or professional education can adequately meet. We are in the midst of a strenuous conflict between the advocates and opponents of sound nursing education. This controversy centers primarily around the student nurse, but the student nurse of yesteryear is the graduate of today. Through the graduate of today we can interpret to some extent the efficacy of past methods. [illegible] implies faulty methods as well as a lack of personal adjustment. If we are going to provide [illegible] for the large number of graduate nurses who are to supplant students in many hospitals we shall doubtless come to realize that teaching, like the poor, we shall have with us always.

Preparation in the fundamentals of nursing varies greatly among graduate nurses. New methods are so rapidly superseding the old that it is utterly essential that nurses be informed of changes and progress in technic. Economy of supplies and time is contingent upon systematic instruction. Habit-formation of students is affected by the standard of practical work among the graduate staff.

Many nurses who graduated some time back did not have their interest stimulated in professional relations

[illegible]

and activities. Training, to many, was a grim experience which had its omega in graduation. It was not intended to be in some cases anything more than a mere preparation for earning a livelihood. Learning, if it were given the major rôle in the nurse's activity, was practical and unrelated, in many cases. The social, economic and diversified educational aspects of professional education were necessarily ignored in a program of simple utilitarianism. Stimuli were repressed both in the individual and in the group because of false concepts of economy.

Industrial organizations long ago recognized that continuous education and training had a marked bearing on production and as a consequence they studied and taught their procedures scientifically. Time studies, the effect of fatigue and numerous other causes and effects were analyzed. If individuals operating machines need systematic instruction how much more necessary it would seem to be that nurses engaged in a highly personal service should have continuous instruction.

From a selfish standpoint alone, excluding any psychological inferences, it behooves a hospital to inform its graduate nursing staff of its policies, its technics, and its equipment. Also there should be some provision for its workers to have the opportunity for comparative study and stimulation from contact with fellow workers.

In a recent article on Russia, in *Harpers'*, one learns that under the Soviet régime the working hours are being shortened to seven in order that more time may be devoted to study. In all plants, apprentices are obliged to attend school for half a working day. The workman must not be so overworked that he has no time for cultural pursuits. It is believed that an unthinking and unadaptable workman can not function highly or make the best use of the instruments placed in his hands. If a nurse is unacquainted with hospital policies and methods in general she may in one day undo all the good that has been done that day.

While the design and execution of a program of nursing-staff education depends, of course, upon the attitude of the executive group, the institutional facilities, the matter of time, and somewhat upon the reaction of the nurses themselves, it is evident that even the simpler and less inexpensive methods are not being as fully employed as they warrant.

Graduate nurses reporting to a hospital for service may, with profit both to the institution and to themselves, be taken on a conducted tour of the institution, the first morning. They should be formally introduced to the heads of the departments. The head nurse or the ward supervisor should devote several hours, either separately or collectively, to the instruction of the new nurse in her immediate duties and in her relationship to her ward environment. This can be supplemented with information given in the classroom by the assistant director of nursing. This is undeniably difficult when one nurse reports, but it can be argued from experience that it is indeed worth while.

The head nurse cannot escape her destiny as a teacher of graduate nurses. Many head nurses will complain that they do not have the time; others confess that they heartily dislike teaching. Many head nurses are immediately coöperative while others are won over more slowly to the program. Perhaps one of the strongest arguments with which to convince the head nurse who at heart is sincerely interested in the welfare of her patients

and the efficacy of her administration is one that shows the immediate relation between efficiency and instruction. To repeat, much depends upon the attitude of the nursing executives. If a nursing director lets it be known at the start that the head nurses are expected to contribute their share in the education of the staff, there will be fewer difficulties. An uninterested nurse may drop out, but one who has latent or lukewarm interest in nursing education will be stimulated to keep pace with her associates.

It is our plan that each head nurse shall have a definite share in familiarizing the graduate nurses and graduate special nurses with the practical procedures. In addition to this, each head nurse is required to choose for group case study, one case on her service. The subject for discussion is reported to the medical librarian at the beginning of the week and is also reported at the end of the week in writing to the nursing office. The head nurse then assigns the reading on this case to all nurses on the unit and the material is set aside on a special shelf in the medical library where it is easily accessible to the nurses. One nurse may be asked to report on symptomatology, another on the therapeutics, another on the dietotherapy, and another on the special nursing measures. At the end of the week a general discussion follows in which all the day nurses take part. The observations on the clinical chart are reviewed and the particular manifestations of the disease in the case studied are discussed. This is done on the ward after morning report.

Graduate nurses coming from other institutions are called upon to describe methods of treatment with which they are most familiar. For instance, a group on one ward last week was studying an unusual case of a young man suffering from cancer of the rectum; the rectum had been excised. Before the group conference took place, the head nurse discovered that one of the staff nurses had had six months' experience caring for such cases. The experience of this nurse prepared her to give a most helpful account of the variety of treatment for such cases and made it possible for her to make several practical suggestions which made the nursing care much less difficult.

Head nurses should be given time to visit other institutions. They should make observation trips particularly to the departments of other institutions in which they are most interested. A nurse in charge of an emergency department can gain much helpful information by a series of visits to factories with well-organized first-aid departments. Staff nurses should be encouraged to make these visits according to their several needs and the hospital should give them sufficient time to go.

It is obvious that the head nurse learns while she teaches but she should not be left out of extra-curricular activities if she desires to take part in them. At various times we have sponsored courses in parliamentary law, public speaking, history of art, and English. All of these courses were designed originally for student nurses but the graduates were admitted. This year the entire graduate staff of supervisors and nurses may take part in our physical-education program.

The following outline may be useful to nursing administrators and educators who wish a concise and inexpensive plan for the introduction of class work for graduate nurses. Flexibility, variation, and group interests are features of this type of staff education as it is interpreted by the writer. It has

as its aim the steady development of enthusiasm in inside work and outside interests.

Classes should meet once or twice weekly. These may be taught by the regular instructors of the school. A carefully prepared syllabus of instruction should be made beforehand. It is believed that every department can contribute something valuable. If the graduate group can have an occasional conference with the dietitian, many simple and careless errors can be eliminated. The nurses who learn the newer trends in dietotherapy will be more valuable to the institution. Recent developments in medicine, surgery, and obstetrics may be subjects of lectures given by the staff. While it may be painful, it is none the less effective to have the graduate group hear, once in a while, the sins of omission and commission of the nursing department recited in a sympathetic and constructive manner by co-workers.

The list of subjects in the outline is merely suggestive. Thirty-six hours of theory were given to a group of graduates last year and additional time is planned for this year. The class work for the staff nurses extends over a period of nine months. The nurses are given definite assignments and they are expected to contribute something to class discussion. All of this takes time but mistakes are costly both in time and money.

Considerable time is given over to the teaching of practical procedures. It is assumed that the nurse knows the principles underlying them. However, when a nurse has been taught to use an elaborate set-up in a treatment such as catheterization, her technic pattern has to be altered if the hospital has a simple set-up. If there is a technic book, it should be used as a guide. It goes without saying that such a book should contain as much information as is needed and that it should be revised as often as necessary. The graduates from other institutions may be most useful in suggesting revisions. Demonstrations may be profitably given. It is not merely a matter of physical equipment but a matter of the nurse knowing how to use it.

It has been our practice to allow one-*half* of the class period for practical nursing procedures and one-half for related or unrelated subjects. The nurses in last year's group became particularly interested in a certain phase of public health and they were given an opportunity to spend some time on the subject. As a consequence one nurse left institutional work and is now doing this particular type of work. Doubtless this type of thing cannot be evaluated in dollars and cents but for that matter can we evaluate an efficient nurse's services in dollars and cents?

The possibilities of education through the professional magazines should not be overlooked. The *American Journal of Nursing* and allied professional magazines should be studied in class for stimulation and information. An institution should require that each of its nurses subscribe for a professional magazine and that each be affiliated with her alumnae and a branch of the American Nurses' Association.

Success in a nurse's work depends not only upon her technical skill, her physical well-being, and her relations with her institution but also upon her social adaptation and her financial security. We have introduced informal talks by agents of reputable life insurance companies, banking houses and investment brokers. Many nurses have made unusual profits as the result.

It cannot be denied that if the nurse

is to be a scientific worker she must develop an attitude that is never static. It is impossible to conceive of either the nurse or nursing in isolation. The nurse is essential to the hospital and the hospital is essential to the nurse. Let the nurse show by her responsive attitude that she is being benefited by instruction and let the hospital adhere to the principle that graduate-staff education is profitable. In submitting this outline such is the sincere belief of the writer.

I. Hospital Technic as Developed by the Department of Nursing:
- Demonstration and discussion of isolation technic, bladder irrigation, catheterization, hot and cold packs, special apparatus for the treatment of fractures, inhalations, etc.
- Technic of administration of insulin. Special problems and their solution in the nursing of difficult cases. Instruction in charting.

II. Hospital Policies and Regulations:
- Reportable cases, visitor regulations, care of the clothes, valuables, care of radium.
- Vacations, sick leaves, salary increases, etc.
- Certain regulations concerning admission and dismissal and transfer of patients.

III. Miscellaneous:
- Legal aspects of nursing.
- Costs of medical and nursing care.
- Costs of hospital supplies, equipment and furnishings.

IV. Professional Education:
- Study of the *American Journal of Nursing* (and the *International Nursing Review*, Ed.,) leaflets on postgraduate courses, alumnae problems, the general-duty situation, nurses' relief funds, registries, placements.
- Special opportunities in the field of nursing.
- Scholarships.
- The trend in nursing affairs.
- Review of the proceedings of the international, national and state nursing organizations.

V. Non-professional:
- Adult education.
- Admission to extra-curricular courses.
- Life insurance, endowments, stocks and bonds.

VI. Observation Trips:
- Intra-mural.
- Extra-mural.
- Visits to departments in the hospital where inter-departmental regulations are explained.
- Visits to other hospitals, sanatoria, and central offices of allied organizations.

Opportunities in Communicable Disease Nursing

A Survey of Experience Offered in Communicable Disease Nursing in the Accredited Schools of Illinois[1]

CHARLOTTE JOHNSON, R.N.

QUESTIONNAIRES were sent out to 136 accredited schools for nurses in June. Responses have been received from 68 of these or about 50 per cent. A good many returning the questionnaire did not fill in some of the most important data, while others were vague in their statements.

In tabulating the replies received, the schools are grouped on the basis of the bed capacity of the hospital in which the nurse received her experience. It is interesting to note that in the first group of 19 hospitals having less than 50 beds, only 4, or 21 per cent, replied. In the second group of 36 hospitals having from 50 to 100 beds, 16, or 44 per cent, replied. In the third group of 35 hospitals having from 100 to 200 beds, 23, or 65 per

[1] Presented at the annual meeting of the Illinois State League of Nursing Education, Moline, Ill., October, 1939.

cent, replied. In the fourth group of 24 hospitals having 200 to 500 beds, 17, or 71 per cent, replied; while in the fifth group of eight hospitals having 500 or more beds, 100 per cent replied.

Questions 1 and 2. Number of beds and average number of patients.

The number of hospital beds was given by the 68 answering, but the average number of patients was given by only 43 reporting.

Question 3. Is there a children's ward connected with the hospital?

Forty-five out of the 68 institutions have children's wards.

Question 4. Number of beds in children's ward.

A total of only 44 beds are available for children in 20 hospitals having less than 100 beds, while 1,310 beds are available for children in 48 hospitals having a bed capacity of over 100.

Question 5. Average number of children exclusive of newborn infants.;

Only 29 averages out of 68 responses were given. Twenty-six gave the total number of children received during the year which could not be tabulated in daily averages. It is evident from replies received that the proportion of children admitted into the larger hospitals is much greater than in the smaller institutions.

Question 6. Are all children isolated on admission to the hospital?

Fifty-two institutions do *not* isolate all children on admission; 13 isolate all children; 3 made no reply.

Question 7. If isolated, for how long?

Twenty-two do not provide for isolation of children on admission; 19 isolate all suspicious cases pending questionable diagnosis, reports from cultures, vaginal smears, etc.; 11 isolate children from one to four days; 2 isolate them from one to two weeks; 14 made no reply to this question.

Question 8. Is there an isolation unit connected with the hospital?

Forty-nine replied in the negative; 19 institutions maintain isolation units varying from one bed to 150 beds, 5 of these reserve units of less than 10 beds, 10 maintain units of 10 to 50 beds and 4 have special departments of 50 to 150 beds.

Question 9. Give types of cases received.

Ten receive the various contagious diseases; 13 care *only* for persons suffering from acute communicable diseases when they develop the infection after they have been admitted to the hospital; 45 made no response.

Question 10. Number of beds in isolation unit.

Fifteen institutions offer a total of 418 beds; 7 receive communicable diseases in private rooms only; 46 either made no reply or have no isolation unit.

Question 11. Average number of patients having communicable diseases.

Only two replied; one gave an average of 2, another an average of 54.

Question 12. Number of students in the school of nursing in 1928.

In 68 schools reporting there was a total of 4,537 student nurses.

Question 13. Number of hours in medical lectures in communicable diseases.

Sixty-two schools report an average of 17 hours. One school gives 48 hours, 12 hours each quarter; another gives 6 hours in all. Six schools give none.

Question 14. Number of hours of nursing lectures or classes in communicable diseases.

Fifty-seven schools average nearly 14 hours' nursing instruction; 11 did not report instruction.

Questions 15 and 16. Is medical asepsis taught during the probationary period? If not, when is it taught?

Fifty-six responded in the affirmative; 5 do not; 5 gave no answer; 10

teach medical asepsis during the first year.

Question 17. What medical cases are isolated in the open wards of the hospital?

Out of a total of 68 hospitals, 27 isolate in the open wards patients suffering from certain types of infectious diseases such as pneumonia, influenza, sore throats, tuberculosis, erysipelas, typhoid fever, dysentery, specific infections, etc.; 29 transfer such patients to private rooms, to two-bed wards or to departments for acute communicable diseases; 6 make no attempt at isolation and 6 did not answer the question.

The incidence of infectious diseases mentioned as being cared for both in the open wards and in the private rooms is interesting. Pneumonia was mentioned 23 times, specific diseases 23 times, tuberculosis 9 times, erysipelas 9 times, typhoid fever 16 times, influenza 6 times, dysentery 4 times, meningitis 3 times, sore throat and streptococcus infections 7 times, septicemia 3 times, skin diseases twice. Encephalitis, fever, discharges, scarlet fever, diphtheria, smallpox, mumps and measles were each mentioned once.

Question 18. What precautionary measures are taken in the isolation of such patients?

It seems probable that various terms are used synonymously in answer to this question.[3] Three practise "aseptic technic"; 11 enforce "strict isolation"; 6 use "individual utensils"; 3 observe the "unit system." Eleven institutions require special nurses to care for acute infections; 3 of these do not permit the nurse caring for such patients to leave the isolation unit nor to mingle with others. Twenty-three definitely state that the nurse is required to wear a gown when attending these patients. Two mention the use of gloves.

Care of hands. Ten refer to the use of various "antiseptic solutions" for the hands; 2 mention scrubbing the hands with soap and water *after* the use of a disinfectant; 1 believes that careful cleansing of the hands with soap and warm running water removes infectious material so that chemical disinfectants are not necessary.

Care of linen. Fourteen use chemical disinfection, 1 steaming, 4 boiling.

Care of dishes and utensils. Nine mention disinfection, 1 steaming, 4 boiling.

Care of discharges. Five collect discharges on cloths or paper napkins and burn.

Care of excretions. Eight practice disinfection of excretions.

Use of screens. Six screen off the patient's bed with all equipment used in his care.

Fumigation. One fumigates the patient's room at termination of isolation.

There is obviously a wide variation of methods in use in the practice of isolation in the hospitals of the state. Greater uniformity in teaching, based upon simple asepsis seems desirable.

Question 19. Is affiliation in a hospital for communicable diseases offered to students?

Twenty-seven schools offer such affiliation; 37 do not. Four are now planning to offer this work to their students.

Questions 20 and 21. How many students completed an affiliation course in communicable disease nursing in 1928? Length of course?

A total of 269 student nurses completed courses of instruction of from one to three months, including bedside nursing care of communicable diseases during 1928.

[3] Further proof of our need for a national [illegible]—Ed.

It is significant to note that during the year there were, in the accredited schools of Illinois, between 6,000 and 7,000 student nurses; that in the 68 schools reporting there were 4,537 students, and that out of this group only 289, or 6 per cent, were adequately prepared by practical experience to give intelligent nursing care to patients suffering from acute infectious diseases, or competent to isolate such persons efficiently with a minimum of inconvenience. Are we fulfilling our obvious duty to the nurse and to the community?

League Calendars

To date 13,981 League Calendars for 1930 have been sold, more than ever before. This is due to the efficient working together of all the calendar committees throughout the states and all of the people who have been helping them.

The result shows what can be done by coöperation. It also shows the real unity of our profession. For these calendars are bought not only by League members, but by nurses in all branches of the work because they believe in supporting nursing education. All nurses realize that they have a part in the entire work of their own profession and certain allied health activities. We support the Red Cross by taking our membership each Thanksgiving. We support the National Tuberculosis Association and its projects by buying Christmas seals every year. In the same way we support work in nursing education by buying a calendar of the League. Nursing education is incurring increasingly heavy responsibilities as the work of the Grading Committee progresses, and the studies show the needs of nursing. How shall the profession, which has given so much toward Grading, best utilize the findings of that Committee? The money derived from the calendars you have bought will help the League in the necessary coöperation as the profession studies to find the best solution of some of the problems in nursing education which are being brought to our attention day by day.

Progress of Nursing in France

An Institute for Directrices and Supervisors of Schools of Nursing under the Auspices of the Ministry of Social Work, Hygiene, Relief, etc., was held in September, and the traveling expenses of the nurses in attendance were paid out of state funds.

In his letter to the presidents of the boards of administration of schools of nursing, the minister stated that "various questions relative to the management of schools of nurses may be studied, with the coöperation of the directrices of recognized administrative establishments which prepare for state examinations and with the approval of the National Office for Social Hygiene."

The following subjects comprised the program for the Institute:

a. The modification of the curriculum to cover these subjects:
   1. The preparation of nurses for the state diploma for hospital nurses (22 months).
   2. The preparation for the state diploma for social hygiene visitors (22 months).
   3. The preparation for the state diploma for hospital nurses and social hygiene visitors (33 months).

b. How to organize the administration of a school of nursing. (Forms, students' records, etc.)

c. Physical examination of prospective students and the supervision of their health during the course.

d. The theoretical courses in relation to the practical experience.

e. The actual problems before social hygiene visitors and how to meet them.

f. How to prepare hospital nurses and social hygiene visitors for the antivenereal disease program.

Addresses were made by Doctor Raphael, Mlle. Chaptal, Mlle. Sagnard, Mlle. de Joannis, Dr. Hazard de Flamalle, Mlle. Delagrange, and Mlle. Greiner.

Department of Red Cross Nursing

DEPARTMENT EDITOR: CLARA D. NOYES, DIRECTOR NURSING SERVICE, AMERICAN RED CROSS

Acknowledgment of Christmas Greetings

FROM far and near, Christmas cards, letters, and gifts came fluttering in to the National Director of the Nursing Service for many days in advance—as well as for many days thereafter—of the most significant and most widely celebrated festal day of the year. We wish we could answer each one of these messages of good wishes but, as there are so many, this would be most difficult. However, we take advantage of this opportunity to thank each individual member of our large Red Cross family for thinking of us. If there is power in thought, especially when concentrated, as many philosophers contend, then we should indeed prosper during the coming year. In any case, we love the messages and appreciate the thought lying back of them, and our days are made happier and less difficult because of them. We thank each one of you over and over again.

Report to National Committee on Meeting of Advisory Committee of the League of Red Cross Societies

WHEN the National Committee on American Red Cross Nursing Service was authorised and organised, one of the duties assigned to it was "to study the nursing service of the Red Cross in this and other countries." When this was written the League of Red Cross Societies did not exist, although many national societies had developed some form of training for the preparation of nurses, largely of the amateur type. When the League was first organized, there was no nursing division or director of such. Questions of nursing, however, began to arise almost immediately. The American Red Cross at that time had a large number of nurses operating in European countries, and was being asked to provide nurses for League nursing activities. The National Committee of the American Red Cross Nursing Service, therefore, early recommended the appointment of a nurse director and later took the lead in recommending an advisory committee of nurses.

As the League was stressing public health, it quite logically followed that the American Red Cross, which had developed an extensive rural Red Cross nursing service, should furnish an advisor on this important phase of nursing. Elisabeth G. Fox, its Director of Public Health Nursing, was chosen. The other advisors are as follows:

Marchesa di Targiana Giunti—Italian Red Cross
Mme. Chaponniere-Chaix—International Red Cross Committee
Mlle. Chaptal—President International Council of Nurses
Frau Oberin von Freyhold—German Red Cross
Mlle. d'Haussonville—French Red Cross
Mme. de Ibranyi—Hungarian Red Cross
Mlle. Kaeckenbeeck—Belgian Red Cross
Miss Reimann—Secretary International Council of Nurses

These advisors on nursing met in Paris on October 24, 25 and 26, and formulated eight recommendations which Miss Fox presented to the

National Committee at its meeting on December 11. Those who have followed the work of the International Council of Nurses will be glad to see that the President and Secretary were present at this conference, and that the principles contained in the report of its Education Committee, of which Isabel Stewart of Teachers College is Chairman, will be used by the League of Red Cross Societies as its guide when called upon to advise Red Cross societies on nurse education. As these recommendations will appear in full in League publications, a résumé only will be given here.

Of the eight, the first and second are more or less routine, while the third deals with the International course at Bedford College, London, its value and continuance, and permanence upon a more secure financial basis.

Recommendation IV considers the relation of the League to the promotion of schools of nursing. The committee approved of the League encouraging the development of schools in countries where conditions are suitable, but urged that the League, through its Nursing Service, first survey the situation in order to determine whether the Red Cross Society of such country is able to support such a project on a sound basis. It further recommended that Red Cross societies encourage government and other agencies to establish schools and also to send suitable individuals to foreign schools for training.

Recommendation V deals with the much discussed question of auxiliary aids. After some preliminary paragraphs, the committee advised "that Red Cross Societies be encouraged to assist in every way with the education of a supply of *fully trained nurses* and their enrollment into a Red Cross reserve; at the same time a body of auxiliary workers should be trained and enrolled as needed." It also recommended that this activity be directed by the Nursing Division, by a Red Cross society in collaboration with national nursing associations, and furthermore that the term "nurse" be used for the fully trained person (the definition of "fully trained" conforms to the American conception of a graduate nurse), and that a different term be used to designate the auxiliary worker. It also recommended that all nurses, whether graduates from a Red Cross school or not, be urged to enroll in the Red Cross reserve.

Recommendation VI recommends that when Red Cross nurses are serving as the reserve of the Army and Navy the privileges of officers be sought for them.

Recommendation VII refers to the use by Red Cross societies of the principles laid down by the Education Committee of the League of Red Cross Societies.

Recommendation VIII emphasizes the importance of using the fully trained nurse for public health nursing but, when these in sufficient numbers are not available, workers of less preparation may need to be prepared and used, and it urges the adoption of the following measures:

1. The promotion of vigorous efforts to educate an adequate supply of fully trained nurses as speedily as possible.
2. The training and supervision of auxiliary workers by public health nurses, carried out in collaboration with schools of nursing and the national nursing associations.
3. The adoption of a title for these workers such as "health aids" which clearly defines their status.
4. The training and use of these workers to be limited to the shortest possible period, and to be regarded as an emergency measure.

The members of the National Committee on Red Cross Nursing Service listened to this report with a great deal

of interest, and were unanimous in their belief that the Advisory Committee of the League of Red Cross Societies had compiled a set of recommendations that were apparently within the reach of practically all Red Cross societies. It also understands that these recommendations cannot become entirely effective until approved by the International Committee of Red Cross Societies. It may be that some Red Cross organization will not utilise them, but unquestionably others will try to put them into practical operation. In doing so, many time-honored ideas and traditions will of necessity need to be abolished.

Unquestionably, the League has a great opportunity to guide Red Cross societies, and to keep them in line with the more modern ideas of nurse education.

Jane A. Delano Recruiting Week

STATE and local committees on Red Cross Nursing Service have again, by means of letters, had their attention called to the utilisation of the week in March which includes the anniversary of Miss Delano's birthday—March 12—for the purpose of interesting young nurses in enrolling in the Nursing Service of this humanitarian organisation. Members of these committees are expected to take the initiative in organising locally for the promotion of the idea and the development of the plan. The Nursing Service in the national and branch offices will be glad to furnish informatory material.

The French Government Makes Financial Contribution to Nurse Education

THOSE who have watched the growth of the fund to complete the unfinished wing of the American Nurses Memorial School building at Bordeaux will be deeply interested, as well as gratified, to hear that the French Government has made a gift of 900,000 francs to the school. We understand that this gift was made to Dr. Hamilton in recognition of her splendid contribution toward the establishment of a modern system of nursing in France, and it is to be used by her to improve the school and the school buildings. The fine work performed by the graduates from the Florence Nightingale School, which occupies the American Nurses' Memorial, in various parts of the country has, we understand, been given as one of the reasons for directing the attention of the Government to Dr. Hamilton's contribution.

A Pioneer Passes On

HANNAH F. CLAPP, whose badge bears the number 78, died recently from pneumonia. Miss Clapp served as a member of the Maine State and the Local Committee on Red Cross Nursing Service from June, 1916, until the time of her death. For eleven years of that period she acted as secretary of that committee, rendering most faithful and efficient service to the Red Cross.

Enrollments Annulled

THE enrollments of the following American Red Cross nurses have been annulled, but their appointment cards and badges have not been returned. It is to be noted that appointment cards and badges always remain the property of National Headquarters and their return is requested when enrollment is annulled: Pauline Marie Sandager; Elva Fae Sater; Mrs. Charles Saunders, née Anna Crouse; Mrs. Harold Schimke, née Augusta Olson; Alma Schlegel; Martha Elizabeth Schoeneborn; Mrs. Ernest Schuerfeld; née Julia Marie Flais; Theresa Crescenthia Schwanzle; Frances May Scott; Mrs. Eleanor M. Sengel; Odessa M. Sheppard; Mabel Inez Sherburne; Ernestine Shirley; Mrs. Fritz Shoquist, née Bertha Sherborne.

Student Nurses' Page

Scarlet Fever: A Case Report

LEAH HESLOP

A Student from Bellevue Hospital, New York City, Affiliating at Willard Parker Hospital, New York City

Outline of the Disease

Definition: Scarlet fever is an acute, specific, infectious disease, highly contagious and characterized by high fever, sore throat, a diffuse, punctate erythematous rash, with a marked tendency to enlarged cervical glands, acute suppurative otitis media, and occasionally nephritis.

History: Sydenham, in 1675, was the first to describe scarlet fever as a distinct disease. At that time scarlet fever and diphtheria were very often confused.

Occurrence: The disease is more prevalent in autumn and spring months, usually endemic, but occurring occasionally in epidemics.

Etiology: The specific cause of the disease is a hemolytic streptococcus. The two Doctors Dick of Chicago, in 1923–24, were the first to satisfy Koch's postulates, apparently proving that a specific streptococcus hemolyticus was the cause of scarlet fever.

The disease may occur at any age but it is most common in children, young adults and in individuals subject to throat infections.

Source: Man—through the nasopharyngeal discharges from active cases, mild and missed cases and carriers, milk and other foods.

Mode of Transmission: The disease is transmitted chiefly by direct contact, but occasionally by indirect contact, as the organism may live a long period of time outside of the body under favorable conditions.

Incubation Period: This varies from one to seven days. The disease is not very infectious during this period.

Communicability: Lasts from the onset of symptoms until two throat cultures, taken twenty-four hours apart, are reported negative, all abnormal discharges have ceased, and all chronic lesions have healed or are negative on culture.

Diagnosis. How Arrived at:

1. Schultz-Charlton Test. This is an intracutaneous injection of convalescent scarlet fever serum in the eruptive stage of the disease. A positive reaction is the complete fading-out of the rash at the point of injection. This is also known as the Blanching Test.

2. Examination of nose and throat cultures. This also aids in differentiating the disease from diphtheria before the rash appears.

3. Clinical symptoms. Fever, sore throat and vomiting usually occur simultaneously at the onset of the disease and are commonly known as the triad of scarlet fever.

Course of the Disease

A. First day:
  1. Abrupt onset.
  2. Headache.
  3. Temperature 103°–104° F.
  4. Nausea with sudden, causeless vomiting.
  5. Sore throat.

B. Second day:
  1. Skin rash which is punctate and bright pink.
  2. Rash on soft palate and roof of mouth.
  3. Circumoral pallor (white area around mouth in contrast to flushed appearance of the rest of the face).

Complications and Their Symptoms

1. Cervical adenitis: Redness, swelling, tenderness of the cervical glands, rise in temperature.

2. Cellulitis: Redness, swelling, pain, edema, rise in temperature.

3. Otitis media: Pain in ear, bulging ear drum, rise in temperature, restlessness, irritability.

4. Mastoiditis: High temperature, pain in or around affected ear, tenderness in mastoid region.

5. Nephritis: Lessened output, dark color of urine, edema under eyes, listlessness, pallor.

6. Arthritis: Swelling, pain, and redness in joints.

7. Cardiac involvement: Change in pulse and respiratory rate, cyanosis, edema. May be detected by stethoscope, pulse rate, electrocardiograph.

Organs Affected and Characteristic Appearance

1. Skin: The skin is covered with a rash which is more noticeable in the axilla, groin, or any fold of the skin. This rash begins on the neck and chest and gradually spreads over the entire body, assuming the appearance of a crimson blush. The rash may be present only a few hours in some of the mild cases. This is important in diagnosis when the doctor is called late.

2. Tongue: The tongue is covered with a furry, white coating which disappears in a few days, leaving it smooth and beefy red with enlarged papillae, having the appearance known as the "strawberry tongue" of scarlet fever.

3. Tonsils: Enlarged and injected.

4. Cervical glands: Enlarged, tender, prone to suppuration and abscess formation.

5. Nervous system: Convulsions are sometimes present in very young children at the onset of the disease.

Prognosis

Variable, due to the virulence of the organism. Mortality rate ranges from 3–90 per cent. In toxic cases the early use of scarlet fever antitoxin shows definite improvement.

Treatment

Rest in bed for at least twenty-one days.

High fluid intake.

Liquid or soft diet. Low protein in nephritic cases.

Ice collar to painful throat or to reduce swelling of glands. If applied early in the disease, it may prevent swelling of glands.

Hot compresses if there is abscess formation in the cervical glands. Surgical interference may be necessary.

Throat irrigations frequently.

Specific serum, intramuscularly.

Special Points in the Nursing Care of a Scarlet Fever Patient

1. The nurse should know that the toxins manufactured by the scarlet fever streptococcus have a highly irritating effect on kidney tissue.

2. For the above reason, long rest in bed and a high fluid intake to dilute these toxins is necessary.

3. Great care should be taken to record accurately the daily intake and output of the patient so that any exchange in condition may be readily checked by the chart.

4. Equipment should be ready and arranged to give throat irrigations frequently with the least possible annoyance or discomfort to the patient. Irrigations are important as the flow of water flushes the organisms in large numbers from the membrane lining the mouth and throat and helps to clear up the disease more quickly.

5. Keen observation, watchfulness and immediate reporting of symptoms indicating complications are important duties.

6. Diet must be nourishing and well suited to patient's condition.

7. Amusement and interests should be provided suitable to the age of the patient which will afford physical rest and prevent mental irritation and restlessness.

8. The patient should be encouraged to sleep two hours each afternoon.

9. Instruction should be given in regard to contamination; *i.e.*, exchanging articles from one cubicle to another, picking up fallen articles. Explanation of procedures and surroundings, duration of illness, and reasons for long period of isolation often prevent unpleasant reactions.

10. Special care should be given during serum reactions and materials used for administration of serum kept ready. These reactions are very severe in some instances and the nurse can do a great deal to relieve the discomfort at this time.

Measures of Disease Control

1. Recognition: Clinical picture and throat cultures.

2. Report: A notifiable and placardable disease.

3. Isolation: For twenty-eight days or until two successive throat cultures, taken twenty-four hours apart, are reported negative.

4. Quarantine: Exclusion of exposed children and teachers from school and of food-handlers from the time of exposure to last recognized case until the end of the incubation period of the disease.

5. Immunization:
   - A. Active:
     1. Natural. White race more prone.
     2. One attack usually immunizes for life.
     3. Scarlet-fever toxin.
   - B. Passive:
     1. Scarlet-fever serum from a convalescent patient.
     2. Scarlet-fever antitoxin. This is of more value as a therapeutic measure in the early stage of the disease, particularly if the attack is serious, than as a method of prophylaxis.

6. Concurrent disinfection:
   - a. Body discharges. From nose, throat and mouth. Gauze or paper handkerchiefs should be used and burned.
   - b. Linen. This is sent dry, in a heavy bag properly marked, to a laundry where special disinfection is carried out. It may be boiled in a covered utensil for thirty minutes.
   - c. Food waste is burned.
   - d. Dishes and treatment utensils. Boiled and thoroughly washed.
   - e. Hand scrubbing. Adapted to the situation, always giving

special attention to the nails.

7. Terminal disinfection:
   a. Cleansing bath, care of mouth, hair, nails, et cetera.
   b. Bedding. Mattress, bedding, et cetera, exposed to sunlight and air for six hours.
   c. Thorough washing of unit with warm water and soap, after which it is allowed to air for at least six hours.
   d. Thermometer containers, et cetera, should be washed with water and soap.

Outline of the Patient's Progress

Social History.

Source: Patient. Reliable.
Name: John Smith.
Age: 21 years.
Nationality: Irish-American.
Route of Admission: Brought to hospital by ambulance, accompanied by nurse.
Standards of Living
Address: 104 E. —st Street. Patient has resided in the same vicinity for many years.

The neighborhood is well populated, but not overcrowded. The homes are of the private type, apartment houses, et cetera. The patient lives on the basement floor of an up-to-date apartment house. The home consists of four rooms, two having outside communication and each has a window. There is running hot and cold water and a private bath and toilet. The apartment is steam-heated and lighted by electricity.

There are three other adults in the family. Two male adults are working and this, plus the patient's earnings, furnish a very comfortable living for the family. The family pays no rent as the mother acts in the capacity of janitress. The patient states that his living conditions are good and that he is very happy with his family, who are congenial and have good social standards.

The patient is a young man of pleasant behavior and moderately high standards. He has finished high school, is able to converse well on many subjects and is ambitious, but quite inclined to dream and drift.

Family Problem Due to Illness.—The patient could not be cared for at home due to the congested living space in the apartment and the contagious nature of the disease. The other members of the family are well at present, with no history of any illness having any bearing on this case.

Agencies Known to.—The patient is a member of St. ———'s Church, but belongs to no organizations of any kind.

Health History.—Height: 5 feet, 7½ inches. Weight: 137 pounds. Slightly underweight.

He has never had any prophylactic treatment of any kind, such as toxin-antitoxin. He is employed as a clerk for the ——— ——— Company. In this capacity the patient handles hundreds of checks and currency daily. This seems to be a very important factor in this case, as it would indicate that he may have come in contact with a carrier through the handling of these bills and checks. He was unable to give a history of known exposure.

Routine of Day.—He arises at 7.30 a.m. and begins work at 9 a.m., lunches at 11 a.m., and leaves his place of employment between 5 and 9 p.m., taking time for only a sandwich to replace his dinner. In all of this time the patient has no opportunity to have a glass of water or milk, as it would take too much time, the facilities being so inconvenient. He has been at his present employment for the past five years.

Exercise.—He walks to and from work, a distance of eleven blocks. Swimming, gymnastics, pool and billiards comprise the balance of his active exercise. For mental amusement the patient reads a great deal and goes to plays and "movies."

Cleanliness.—He bathes twice a week, washes his hands thoroughly before each meal and keeps his nails short and clean. The skin and eyes are clear and his hair is in good condition. His mouth hygiene is not very good, but his teeth appear in excellent condition, considering the fact that they are brushed only "occasionally."

Diet.—Breakfast: Varies, but is never well balanced. Usually consists of an egg-nog. Luncheon: Varies also, such as spaghetti or a hot lunch, including meat. Always has vegetables for lunch. Supper: Usually consists of a sandwich and milk. John likes milk and drinks a great deal of it. He states that he is also very fond of vegetables. He seldom drinks tea or coffee, uses alcoholic beverages infrequently and smokes moderately. He eats his meals at various restaurants, which may have a bearing on contact with the disease.

Sleep.—His hours of rest are quite irregular, retiring between the hours of 11 p.m. and 1 a.m., as a rule. He sleeps with a younger

brother, aged 10 years, and they always have the windows open while sleeping.

Social Behavior.—He prefers to be alone most of the time. He would like to have company, but does not care to indulge in the pleasures of the average youth. The patient seems to be the slightly introverted type. He likes to play a "good game of pool," and is interested in sports and daily topics. He reads fairly good literature, but could improve upon his taste with advantage to himself. His home life is very happy, as he is extremely fond of his parents and "likes to do the right thing."

Medical History.—Childhood: Measles and whooping cough.

Present Illness.—At work on Monday, April 1, 1929, the patient felt his throat becoming sore. It became progressively worse during the day, and by night it was quite difficult for him to swallow. He consulted the family physician and, having a temperature of 103 degrees F., was advised to go to bed. He was seen in the morning by the doctor and there was no rash, nausea or headache. Severe itching began on Wednesday morning and the rash appeared shortly afterwards, beginning on the chest and abdomen and spreading to the lower arms, thighs, and extremities. It was light at first and then became scarlet. The throat was not sore. On Thursday the Board of Health was notified and the patient brought to Ward IV-6 at 9 a.m.

Symptoms Before Entering Hospital.—Sore throat, rash and itching, fever weakness.

Symptoms on Admission.—Headache, scarlet rash, pain in left foot and around toes.

Objective Symptoms.—Marked confluent, diffuse, punctate erythematous rash covering the entire body, and accentuated at the flexion joints. Tongue coated. Throat reddened and deeply injected. No membrane present and no edema of throat. Temperature, 100.6° F.

Physical Findings.—Urine negative for albumin throughout course of disease. Chest and lungs clear. No glands palpable. Cultures positive for hemolytic streptococcus. Profuse purulent discharge from superficial blisters covering toes of left foot.

Course of Disease.—The rash began to disappear on the second day after admission and was entirely gone on the fifth day. Desquamation began on the tenth day from onset. The temperature was normal on the sixth day and remained so except for twelve hours, when the patient had a slight serum reaction. At that time large blotchy areas appeared on the skin and the patient's temperature went up to 100.6° F. The reaction was of short duration and caused little discomfort. The tongue became scarlet with enlarged papillae about the sixth day. After the ninth day the patient began to feel very well and has had no complaints. Desquamation had almost cleared up by the nineteenth day. The patient was feeling very well on the twentieth day and the physician reported good progress.

Treatments.—Forced fluids. To dilute toxins and prevent kidney complications.

Nourishing diet of low protein content, to avoid overtaxing the kidneys.

Rest in bed. Encouraged to lie as quietly as possible, to avoid overtaxing the heart.

Schick, Dick and Sensitivity Tests, vaccination, nose and throat cultures, and administration of 5,000 units of scarlet-fever antitoxin were included in the admission of the patient to the hospital. The nose and throat being the lodging place for this particular germ, cultures were taken to find the specific organism.

Gentian violet applied to foot. Condition cleared up in six to eight days.

White vaseline to desquamating areas.

Calamine lotion during serum reaction.

Medication.—Cathartics. Codein and aspirin on admission for sleeplessness.

Diagnosis.—Scarlet fever, uncomplicated at present. This diagnosis was arrived at by the clinical picture presented, the positive report of the nose and throat cultures and the Schultz-Charlton Test.

Prognosis.—In this case the prognosis is very good because the patient was brought to the hospital in an early stage of the disease and the treatment was started at once. It is also favorable because there are no complications and the attack was mild.

Desirable Environment on Discharge.—Any place where rest, good food, fresh air and contentment can be obtained.

Mental Aid Given.—Explanation about the disease and the expected usual outcome. Encouragement to lie quietly in bed. Cards of correspondence cared for and books obtained for patient's amusement.

Physical Aid and Health Habits Taught.—The patient was made as comfortable as possible during the course of the disease. Discussion of better personal hygiene advised, and reasons given, with much interest shown.

References:

Doctor's lecture.

Pillsbury's Nursing Care of Communicable Diseases.

American Journal of Nursing.

Discussions with head nurses and doctors.

The Open Forum

The editors are not responsible for opinions expressed in this department. Letters should not exceed 250 words; anonymous letters are not considered

Our Inheritance

MISS CORNELISEN, representative of the *American Journal of Nursing*, visited our school December 3. We hope she enjoyed the visit as much as we. The talk delivered to the student body was both interesting and inspirational, her subject being "Our Inheritance." When a person speaks of an inheritance we immediately wonder what kind, when and where did they receive it. That is just the question that arose in our minds when Miss Cornelisen spoke of a nurse's inheritance. What could a nurse inherit? We didn't wonder long, for Miss Cornelisen painted a beautiful picture in words that told us the untiring work of our ancestors. . . .

When Miss Cornelisen finished, we felt much better acquainted with the *Journal*, although we had been using it in our work since we entered the school of nursing. Knowing its history, being made familiar with the courage and faith of those who pioneered it, seems to give the *Journal* an animate quality and leads us to really desire a closer intimacy with "our inheritance."

N. D. C.

Freeman Hospital,
Joplin, Mo.

Out of the Mailbag

I

I ENJOY reading the *Journal;* it is like a friend coming to visit me each month. I am doing private duty nursing out here in my home town. I come in contact with all kinds of nurses; many of them seem so careless. I welcome "our" magazine because it shows what wonderful conscientious nurses there are in the world. I am glad all nurses do not "do as they please" when they finish training.

W. M. S.

New York.

II

It is quite noticeable that the editors of the *American Journal of Nursing* have resolved to make [illegible] the best ever if one may judge the January issue.

From cover to cover, it is full of many inviting things to members engaged in all branches of the profession.

I. E. M.

Michigan.

III

Many times this year I have wanted to tell you what a help the *Journal* is to us here. The staff has a weekly medical society and when my turn comes to report I always use the *Journal*. The doctors frequently borrow my copies when they are following up a treatment. Now I have a file just for *Journal* articles on treatments and new devices.

G. K.

China.

A Private Duty View of the Future

TOO many nurses are practising practically everywhere and there is not enough demand to keep them employed. Yet, as a rule, these nurses persevere, hoping that each year will be more prosperous than the one preceding, only to be disappointed.

What is to be done about it? If we continue to accept things as they are, there will be no improvement, but increasing supply and decreasing demand for services.

The public is assured of good service when they engage a registered nurse. This has been regulated by the laws of the states. Yet the number of nurses registering each year in most places is greater than the number the past year.

Good students graduate from accredited high schools and find themselves with no special talents, but a great deal of ambition. They are at a loss to know just which profession or vocation to prepare themselves for. Being ambitious, they make inquiries, are advised or warned, as the case may be, and come to a satisfactory conclusion. Too often for the economic good of the profession, and of the girl herself from a financial standpoint, she chooses to become a nurse.

There are undoubtedly many advantages in this work to a girl, even though she does not intend to practise after completing her course. The student receives knowledge and a direct contact with human nature in a manner which she could never do in another field. In training, her expenses are minimum and her professional contacts are many. It is a work whose appeal can be resisted by few. Then,

after completing her difficult and strenuous training course, the young nurse finds herself with new problems to confront, and new fields to conquer. The largest of these obstacles is greater supply than demand for nurses.

The solution, as in many other enterprises, is purely one of education. If the educational requirements insisted upon were one or two years' college training, rather than the high school diploma, there would be fewer applicants for training schools and better students. Heretofore, the chief object has been to meet the needs of the hospital by maintaining a training school at a minimum cost. After a nurse is registered, it is up to her and to the profession to meet existing conditions.

If training schools in larger hospitals were supplanted by registered nurses, and the theoretical work of the students transferred to the colleges, a much higher standard of efficiency could be obtained and this situation improved. A college course in nursing, consisting of three years' theoretical work and one year of internship in practical work in a hospital, would indeed provide a nurse about to enter the field with a better knowledge and greater ability to combat the problems which will necessarily confront her. At the same time the profession as a whole will be elevated and existing conditions, which are a source of agony to the graduates of the present, will be removed.

MARGARET IRENE MILLER, R.N.

Indiana.

Relief for Eczema

I WISH to describe an experience which has been very beneficial to my present patient, an eczema case of long standing.

After trying several lotions and powders, the doctor suggested that we try any alkaline preparation in solution, such as magnesium sulphate or milk of magnesia, with cocoa butter or cuticura ointment. While giving the patient milk of magnesia internally we decided to try it externally as well, saturating balls of absorbent cotton with it and gently patting all the irritated surfaces. It seems to give considerable relief. During the night I apply cuticura ointment which softens the crusted areas. Then I bathe them with clear tepid water and apply milk of magnesia and bandages. I find that the redness and irritation are much decreased.

Illinois C. I. H.

Too Many Nurses Here, Also

DISTRICT 6-B of Arkansas State Association (Hot Springs National Park) does not wish to be inhospitable but advises nurses planning to come here to do private duty that unemployment is a serious problem in that branch of nursing here, many local nurses not making enough to live.

ETTA B. RADFORD, *President*

Arkansas.

Journals on Hand

LOUISE JANSEN, Orange City, Tenn., will sell for 10 cents each, and postage, the following copies of the *Journal:* 1917, all except April and September; 1918, all except May and June; 1919, all except June and July; 1921, March through December; 1924, all except September.

Lena M. Bleich, 4825 Hazel Avenue, Chicago, Ill., will give away these copies of the *Journal* if postage is sent: October, 1927, to the present time.

Journals Wanted

S. BELLE MACCALLUM, Butterworth Hospital, Grand Rapids, Mich., is trying to complete a file and needs the following copies of the *Journal:* Volumes IV, IX, X, all numbers; Vol. XI, September; Volume XV, August.

Questions

What ethical principles are involved in calling special duty nurses for hospital cases? Are patients usually privileged to take nurses of their own selection with them without consultation with the superintendent of nurses?

Answer.—The superintendent of nurses is usually held responsible for all nursing in the hospital, special duty included. This being the case, it is only just that she should be allowed to select those for whose acts she must be responsible, and patients desiring special nurses should consult her, either directly or through their physicians, before completing arrangements for admission to the hospital.

Some hospitals have a ruling to the effect that special nurses must be called through definite channels, such as the registry of the alumnae association or some other official registry. Since this is so, it is especially important that the nurse who is "a friend of the family" should have a clear understanding of the rules of the nursing service of the hospital before committing herself to the case of a particular patient.

A happy solution of the friend or relative problem has often been found by permitting the friend to act as companion, while the hospital provided nursing service in accordance with its own standards.

The ethical principles involved, therefore, are those having to do with the placing of responsibility and with respect for established custom. Courteous recognition, on both sides, of these principles, tends to allay friction.

Should a nurse who has contracted to take an obstetrical case on November first, take a case on October first, which is certain to last from six to eight weeks, without telling the physician of the contract with, or promise to, the obstetrical patient?

Answer.—The answer is obvious. The question, however, is not hypothetical. A physician raises it because he had the experience of employing a nurse who failed to tell him that she could not nurse his patient through the course of treatment planned. The physician *should* have been informed. He, alone, could decide whether it would be unwise or unfair to his patient to change nurses at the end of a few weeks. The patient's welfare is of paramount importance.

Is there danger that the milk of a syphilitic woman may infect a non-syphilitic child, so that the disease may be transmitted by wet nurses or by the women who supply milk stations?

Answer.—It has been stated on good authority that there has never been any evidence that the causative agent of syphilis is secreted in mother's milk. There have been instances where a baby has been put to the breast of a syphilitic woman who had a fissure in her nipple, through which the baby became inoculated with syphilis.

The collection of milk, under ideal conditions, from mothers, even though those mothers have not been examined for syphilis, and dispensing it for the use of babies, in all probability carries with it no risk provided the milk is pasteurized before use. It is a wise precaution, however, to make a Wassermann test on every woman before collecting the milk from her for the use of other babies.

News

Note.—News items should be typed, if possible, double space, or written plainly, especially proper names. All items should be sent before the 15th of the month preceding publication.

The American Nurses' Association

Board and committee meetings, annual reports and tentative programs, the keen eye of analysis turned backward over the past year in order to see clearly the path for the coming year. In other words, January.

Headquarters always looks forward to Board meeting time. It is apt to dress up a little for the occasion. This year it installed a diminutive dressing table with pins and powder. And in the same way, it puts its finishing touches to reports, made final check-ups on the year's work and the coming year's program, and made ready to receive its guests.

Headquarters Reports

There was real progress for Headquarters to report to the Board of Directors. Perhaps it is the renovated and enlarged offices that have added impetus to the work. Or perhaps like a well-oiled machine, it is moving rapidly on its own momentum. Be that as it may, a full year's work was done at National Headquarters in 1929.

Available Information

One of the directions in which constructive advance has been made is in that of assembling information at Headquarters. Whenever a letter is answered that has required research on a subject, a copy of that letter is placed in the Form Letter Book. The Compendium of Information has been brought almost up to date. The Presidents' Portfolios—a matter of pride at Headquarters—have been dispensed and added information forwarded. The subject matter in the *Bulletin* has been directed along simple, practical lines, and in every way Headquarters has tried to fulfill its function of helpfulness to the constituency.

Projects

There were several significant projects to report to the Board, significant because they also are indications of the way in which the American Nurses' Association is facing the problems of its members. Of course, there was the Relief Fund with its story of suffering and of the nurses' answer to the plea of suffering. And there was the Bordeaux School Campaign with the record of the astonishing generosity of the nurses of America, and their over-subscription by more than $6,000 in completing the memorial to those of their members who gave their lives in the World War.

Nursing Economics

Nursing economics, low income in private duty, the problem of distribution of private duty service, these problems also are being studied as A. N. A. projects. The Board heard reports of the progress of the Registry study, the Hourly Nursing Study in Chicago, and the Survey of Government Service Nurses.

Status of Government Nurses

The last-named survey is of keen interest to all nurses because of its implications in the matter of professional status. The situation leading up to the study was this:

In order that positions of Government services might have a uniform relationship in the various departments, *The Classification Act of 1923* was passed. This *Act* provided for the classification of civilian positions, the nurses affected by it being those belonging to the United States Public Health Service, United States Veterans' Bureau, United States Indian Service. An amendment to this Act, with reference to occupational status and, as a result, to salary rates, now is being considered. In order that the position of the American Nurses' Association with regard to

this amendment might be based on exact information with respect to Government nurses and the manner in which they would be affected by this amendment, the services of the A. N. A. Headquarters Director were given to this study.

The Cost of Health

Almost as sure to recur in print these days as news about the latest blizzard, are articles on the high cost of sickness. The January issue of the *Survey Graphic* contains various viewpoints on the subject under the general title, "The Cost of Health." Nursing in the home takes its place in this discussion with an article by Janet M. Geister. Writing on "The High Cost of Nursing," Miss Geister states the present paradox in private duty nursing.

"I do not believe," she writes, "the average patient can pay more than he is paying today for his nursing care. Rather, he should pay less and have more of it available in the quantity and quality that he needs."

But "The private duty nurse cannot charge less than she is charging. She has reached the lowest level of annual income compatible with any degree of comfort and safety to the patient. . . . The nurse should have a larger or more regular income."

In this article the Headquarters Director shows the progress already made by the nursing profession to supply expert nursing service, under supervision, at rates which people can afford, and at the same time provide nurses with regular employment and income, vacations and a chance for advancement.

Convention News

Glenn Frank, President of University of Wisconsin, will be the principal speaker at the opening meeting of the Biennial Convention of the three national nursing organizations, Monday evening, June 9, in Milwaukee. Dr. Frank, whose ability as a gifted speaker is widely known, will follow on its program those representatives of the city and state who will welcome the nurses to the Wisconsin city.

Announcement of Dr. Frank's acceptance of the invitation to address the national nursing bodies [illegible] a most propitious beginning in the [illegible] of the convention program. Following the meeting of the boards of directors of the [illegible] organizations being held as this copy goes to press, it is expected that definite advances will be made rapidly in program and [illegible] along the lines suggested during the board sessions.

Rochester Trip

Wisconsin is such a near neighbor of Minnesota that a number of nurses attending the convention will want to visit the Rochester clinic and hospitals while they are in that part of the country. Since inquiries already have been made with reference to such a trip, the Convention Committee has interviewed officers of the Nurses' Association in Rochester.

This Minnesota group extends a very cordial welcome to the nurses of the country. If there are enough requests for the trip, a special train will be provided to Rochester, and a program and entertainment will be arranged for a certain post-convention day, probably June 14. Nurses wishing to visit Rochester are asked to notify their transportation chairman, or A. N. A. Headquarters, 370 Seventh Avenue, New York City.

First Transportation Plans

The first definite arrangements in transportation have been made for a group of eastern cities. Plans have been completed with the Baltimore and Ohio; with the Chicago and Northwestern; the Chicago, Milwaukee and St. Paul; and the Santa Fé railroads for the operation of special trains. June 7 is the date for the trains which will leave New York via the B. & O. and will stop for convention goers to join those already aboard at Elizabeth, Philadelphia, Baltimore, Washington, Pittsburgh and intermediate points.

The itinerary of this special group of trains is as follows:

Saturday, June 7

Lv. New York, 32d Street Station, B. & O. R. R., 10.35 a.m.

Lv. Philadelphia, 24th and Chestnut Streets, B. & O. R. R., 1.23 p.m.

Lv. Baltimore, B. & O. R. R., 3.25 p.m.

Lv. Washington, D. C., B. & O. R. R., 4.30 p.m.

Sunday, June 8

Ar. Chicago, B. & O. R. R., 1.30 p.m.

Lv. Chicago, C. & N. W. or C. M. & St. P., 3.00 p.m.

Ar. Milwaukee, C. & N. W. or C. M. & St. P., 4.45 p.m.

Nurses' Relief Fund

Report for Month Ending December 31, 1929

Receipts

Interest received on investments..........	$340.24
Interest received on bank balance.........	134.15

Contributions

California: State Nurses' Assn.	$87.50
Connecticut: Graduate Nurses' Assn.	556.50
Delaware: Delaware Hospital, $1; Homeopathic Hospital, $1; individuals, $4	6.00
District of Columbia: Graduate Nurses' Assn.	61.00
Florida: Districts—5, $20; 11, $41; 12, $5; Keller Alumnae Assn., Tampa, $32	98.00
Georgia: Individuals	10.00
Maine: Central district, $81; Eastern, $75; Western, $25; Alumnae Associations—Children's, $15; Maine General, $31.50; Maine Eye and Ear Infirmary, $140; Trull, $9; St. Barnabas, $15	391.50
Maryland: Alumnae associations—Univ. of Maryland, $100; Maryland Homeopathic, $15	115.00
Massachusetts: Alumnae associations—Memorial, Worcester, $5; Worcester City, $25; McLean, $10; Massachusetts General, $50	90.00
Minnesota: Alumnae associations—St. Luke's, Duluth, $3; Northwestern, $12; St. Barnabas, $1; Bethesda, $10; St. John's, $15; Ancker, $5; St. Lucas, Faribault, $[illegible]	57.00
Mississippi: State Nurses' Assn.	395.50
Missouri: Lutheran Hospital Alumnae Assn.	1.00
Nebraska: State Nurses' Assn.	6.00
North Dakota: State Nurses' Assn.	79.00
Oklahoma: Districts—1, $54; 3, $12; 4, $10; 5, $29; University Hosp. Alum. Assn., $6	111.00
Texas: Districts—1, $97; 2, $49; 5, $19; 6, $41; 10, $55; 11, $97; 15, $4; 16, $26; State Nurses' Assn., $100	488.00
Utah: T. N. T. Club, Salt Lake City	20.00
Total contributions	$2,572.00
Total receipts	$3,547.39

Disbursements

Paid to 191 applicants	$2,772.00
Salaries	254.16
Postage	10.00
Stationery	.80
Total disbursements	$3,036.96
Excess receipts over disbursements for month ending December 31, 1929	$510.43

All contributions to the Nurses' Relief Fund should be made payable to the *Nurses' Relief Fund* and sent either to the person who collects your dues or to the local Relief Fund chairman. The method for collection of contributions varies in each state. Your district president or treasurer can tell you to whom your checks should be sent. For application blanks for beneficiaries, apply to your own alumnae or district association, or to your state chairman. For leaflets and other information, address the state chairman, or the Director of the American Nurses' Association Headquarters, 370 Seventh Avenue, New York, N. Y.

Isabel Hampton Robb Memorial Fund

REPORT TO JANUARY 9, 1930

Previously acknowledged	$34,671.62

Contributions

Delaware: State Association	10.00
Indiana: District 4	5.00
New York: Brooklyn, Brooklyn Hospital Alumnae	10.00
Pennsylvania: District 3	5.00
West Virginia: State Association	5.00
Total	$34,706.62

MARY M. RIDDLE, *Treasurer.*

McIsaac Loan Fund

REPORT TO JANUARY 9, 1930

December 9, 1929, Balance	$251.32

Contributions

Connecticut: State Association	200.00
Delaware: State Association	10.00
Illinois: Illinois Training School Alumnae	50.00
Indiana: District 4	5.00
New York: Brooklyn, Brooklyn Hospital Alumnae	10.00
Pennsylvania: District 3	5.00
West Virginia: State Association	5.00
Repayment on loan	35.00
	$571.32

Disbursements

Loan made	200.00
January 9, 1930, Balance	$371.32

MARY M. RIDDLE, *Treasurer.*

Contributions to these two funds are solicited from associations or from individuals. Checks should be made out separately in the name of the fund and sent to Mary M. Riddle, Treasurer, Care *American Journal of Nursing*, Room 1610, 370 Seventh Avenue, New York, N. Y.

To Study Nursing Conditions in the Orient

Annie W. Goodrich, Dean of the Yale School of Nursing, has been invited by the Rockefeller Foundation to make a study of nursing conditions in the Orient in company with Mary Beard, Assistant Director of Medical Sciences for the Foundation. Their primary visit will be made at the Peking Union Medical College, and at St. Luke's International Hospital at Tokyo.

Chief among the problems in which Dean Goodrich and Miss Beard will be interested is the Public Health Movement in the Orient,

especially in its relations to graduate and undergraduate instruction for nurses. A three months' leave of absence has been granted Miss Goodrich, who has been at the head of the Yale School of Nursing since it was founded in 1923. The Rockefeller Foundation recently gave $1,000,000 toward the endowment of the school in recognition of its efforts to raise the standards of nursing education.

National League of Nursing Education

Addresses Wanted

Copies of the 1929 Annual Report mailed to members listed below, in addition to those listed in the January *Journal*, have been returned because of incorrect address. If these members will notify League Headquarters, 370 Seventh Avenue, New York, of their proper address, their reports will be forwarded at once and postage for remailing charged to them. The addresses given are the last ones known.

Campbell, Hermione, West Palm Beach, Fla.
Cope, Ethel, San Francisco Hospital, San Francisco, Calif.
Curtis, Anne S., Alley Hospital, Marblehead, Mass.
Ellison, M. A., Masonic Hospital, Cherokee, Okla.
Gilbert, Helen, St. Joseph Hospital, Omaha, Neb.
Halle, Elizabeth, Indiana Christian Hospital, Indianapolis, Ind.
Halverson, Amy, 863 N. 15th St., Milwaukee, Wis.
Hofmeister, Rose, Fish Creek, Oneida County, N. Y.
Keller, Doris, St. Luke's Hospital, Denver, Colo.
Lawrence, Bessie, 707 Fullerton Avenue, Chicago, Ill. (not the Miss Lawrence now at Lakeside Hospital, Cleveland)
Lawton, C. G., St. Francis Hospital, San Francisco, Calif.
Lyle, Maude E., 120th Street and Morningside Drive, New York City.
McDonald, Lillian, 1128 Madison Avenue, Baltimore, Md.
[illegible], 9825 S. New Hampshire Street, Los Angeles, Calif.
[illegible] Edith L., Samaritan Hospital, Troy, N. Y.
Nelson, Elvira, 901 S. Iowa Street, Mitchell, S. D.
Olson, Anna M., 1455 Winnemac Avenue, Chicago, Ill.
Specht, Florence A., Rutherford Hospital, Murfreesboro, Tenn.

Army Nurse Corps

During the month of December, 1929, orders were issued for the transfer of members of the Army Nurse Corps to the stations indicated: to Army and Navy General Hospital, Hot Springs National Park, Ark., 2nd Lieut. Jane Coddington; to Fort Benjamin Harrison, Ind., 1st Lieut. Elsie Neff; to Fort Benning, Ga., 2nd Lieuts. Grace M. Harrison, Sarah E. Williams; to Fort Leavenworth, Kans., 2nd Lieut. Frances M. Sternberg; to Letterman General Hospital, San Francisco, Calif., 2nd Lieut. Ella M. Turner; to Fort McPherson, Ga., 2nd Lieut. Margaret Wendelken; to Fort George G. Meade, Md., 2nd Lieut. Mabel G. May; to Fort Monroe, Va., 2nd Lieut. Arnie Lee Duke; to Fort Riley, Kans., 2nd Lieuts. Taletta Haraldson, Elva M. McCalmon; to Fort Sam Houston, Texas, 1st Lieut. Ida W. Danielson, 2nd Lieuts. Emily Gibson, Lena M. Schumacher; to Fort Slocum, N. Y., 2nd Lieut. Erba C. A. Rorby; to Walter Reed General Hospital, Washington, D. C., 2nd Lieuts. Maidie E. Tilley, Ione Featherstone; to General Dispensary, Washington, D. C., 2nd Lieut. Bernice W. Chambers; to the Station Hospital, San Juan, Porto Rico, 2nd Lieut. Maude M. McKinney; to the Hawaiian Department, 2nd Lieuts. Karen M. Swarva, Della Alberta Ward; to the Philippine Department, 2nd Lieuts. Helena Clearwater, Helen M. Bortres, Margaret E. Aaron, Florence E. Halverson, Christine M. Burton, Nettie H. Erdenberger, Delila M. Sparks.

Four have been admitted to the Corps as 2nd Lieutenants.

The following-named are under orders for separation from the Corps: Lucinda W. Palmer, Edith A. Mattoon, Louise Burroughs, Kathryn S. Conners, Myrtle A. Gibson, Marbin H. Johnson, Bernice Hubbard, Myrna M. Riggs.

Julia C. Stimson,
Major, Army Nurse Corps,
Assistant.

Navy Nurse Corps

During the month of December, nine nurses were appointed and assigned to duty.

Transfers: to Boston, Mass., Cornelia A. Armstrong; to Mare Island, Calif., Laura V.

White; to New York, N. Y., Myn M. Hoffman, Chief Nurse; to Norfolk, Va., Mary M. Kenney; to Pensacola, Fla., Beulah Duxbury; to St. Thomas, V. I., Mary M. Maney, Chief Nurse, Ethel Jean McCormack.

The following nurses have been separated from the Service: Louise E. LeClair, Velma Schultz, Bertye L. Wise.

During the year of 1929, speakers from the Navy Nurse Corps have been invited to address groups of nurses, both graduates and students, to present the opportunities in the field of nursing in the Navy. Addresses were given by the Superintendent to the West Virginia nurses at their annual meeting at Bluefield; by Clare L. DeCeu, Assistant Superintendent, to groups throughout the states of Idaho, Wyoming, Oregon, Montana, Washington and California, one trip covering the period from June 4 to September 30; by Anna G. Davis, Assistant Superintendent, to groups throughout the states of Ohio, Michigan, Iowa, Illinois, Tennessee, Kansas, Mississippi, Louisiana, Arkansas and Wisconsin; by Betty W. Mayer, Assistant Superintendent, to nurses in Philadelphia and to the North Carolina nurses at their annual meeting at Wrightsville Beach; by Anna E. Gorham, Chief Nurse, at Plainfield, N. J.; by Isabelle F. Erskine, Chief Nurse, at Taunton, Mass., and at Providence, R. I.; by Mary D. Towse, Chief Nurse, to nurses of the Fourth District Association of Virginia, at Portsmouth; and by Elsie Brooks, Chief Nurse, at Seattle, Wash.

J. Beatrice Bowman, R.N.,
Supt., Navy Nurse Corps.

U. S. Public Health Service

The following reinstatements and new assignments have been made in the U. S. Public Health Service during the month of December, 1929:

Reinstatements: Josephine Taylor, U. S. Marine Hospital, Boston, Mass.

New Assignments: Alida Guidry, U. S. Marine Hospital, Stapleton, N. Y.; Alma Carlson, U. S. Marine Hospital, Pt. Townsend, Wash.; Helen Pierce, U. S. Marine Hospital, Ellis Island, N. Y.; Mattie Ruth Bell, U. S. Marine Hospital, Ellis Island, N. Y.; Claudia L. Polski, U. S. Marine Hospital, Ellis Island, N. Y.

Respectfully,
Lucy Minnigerode,
Supt. of Nurses, U. S. P. H. S.

United States Veterans' Bureau

Report of Nursing Service

Better methods by means of which the nursing personnel of this Bureau might serve more efficiently are ever being devised. In fact, "Service" is the keyword of the slogan for a greater organization. Increased facilities to care for the disabled veterans will be available through the authorization by the Congress of $15,950,000 for new hospitals —the bill has been signed by President Hoover and is now a law. The construction authorized under this bill is: for Bedford, Mass., 150 beds; New York, N. Y., 1,000 beds; New York City, 200 beds; western New York State, 400 beds; Augusta, Ga., 138 beds; Alabama, 250 beds; Gulfport, Miss., 138 beds; Indiana, 150 beds; North Chicago, 150 beds; Knoxville, Iowa, 150 beds; Albuquerque, N. M., 250 beds; San Francisco, Calif., 200 beds; Tucson, Ariz., 100 beds; Texas, 300 beds; Hot Springs, Ark., 500 beds; Camp Custer, Mich., 100 beds; Utah, 100 beds; West Virginia, 165 beds; Memphis, Tenn., 50 beds; grand total, 4,491 beds. Many more nurses will be needed. A special study of the question of future hospitalization of all American war veterans has been begun by an Executive Committee of the Medical Council of the Bureau, meeting at the call of the Director, in compliance with a request by President Hoover.

During January, 1930, the Superintendent of Nurses visited the U. S. Veterans' Hospital, Bronx, N. Y., to supervise the nursing activities and in connection with the establishment of the postgraduate course for nurses now being inaugurated at that hospital.

Without assuming a prophetic attitude one can safely predict that this nursing organization may look forward to a new year of efficient help and valuable service.

During the month of December, 1929, orders were issued for transfer of the following named nurses:

To U. S. V. H., Dwight, Ill., Viola Lorch; to N. Little Rock, Ark., Mary Beall; to Northport, L. I., N. Y., Minnie E. Bellamae.

The following were reinstated: Mary W. Edwards, Philomena Marshall, Margaret L. Stone, Alice Armstrong, Lucile Adcock, Anna R. Jones, Sara Blackwell, Flora Ritchie, Theresa Jost, Mary M. Brown, Ella Cox.

Twenty-seven new assignments were made and the following-named have been separated from the service: Clara G. [illegible], Ethel J. Bordeaux, Marguerite [illegible], Ethel R. Burkhalt, Pauline J. Burke, Mabel C. Carlson, Anna Coffey, Virginia E. Compton,

Edith H. Dean, Anna E. DeVore, Gertrude Engle, Cora A. Fomby, Elisabeth D. Gaffney, Nellie L. Gillespie, Mary Hall, Caroline E. Hann, Florence E. Hagberg, Marian Holmes, Clara K. Jones, Mary Keirns, Sylvia Kelly, Amy B. Lofiar, Harriet V. Meloney, Genevieve McGuigan, Ethel L. McMillan, Marion Murphy, Mabel M. Nelson, Mary P. Nicholls, Josephine A. Phelps, Mary A. Prince, Lydia M. Richter, Clara C. Roberts, Nina Wallace, Miriam F. Weinberg.

MARY A. HICKEY,
Supt. of Nurses.

U. S. Indian Service

REPORT TO DECEMBER 12, 1929

Appointments: twenty-six.
Separations: eight.
Transfers: To Cherokee, N. C., Mary Buford; to Rapid City. S. D., Caroline K. Gardner, Chief Nurse; to Shawnee, Okla., Mrs. Grace T. Bonnete; to Mt. Pleasant, Mich., Linnea Anderson.

Sallie Jeffries has been recently appointed as Assistant Supervisor of Nurses in the Indian Service. Miss Jeffries served overseas with Base Hospital No. 5 and following the war she has been employed in public health work with the Veterans' Bureau and the United States Public Health Service. Miss Jeffries will be occupied most of the time in making visits to the field stations in a supervisory capacity. Thus is another step taken in bringing the needs and conditions of work among the Indians closer to headquarters.

American Conference on Hospital Service

The annual meeting of the AMERICAN CONFERENCE ON HOSPITAL SERVICE will be held on February 18, in Chicago, in conjunction with the meeting of the Congress on Medical Education, Hospitals, Medical Licensure and Public Health.

Morning Session: A symposium on the "Cost of Medical Care" from the point of view of (a) the hospital, Bert Caldwell, M.D., Executive Secretary American Hospital Association; (b) the hospital staff, James B. Herrick, M.D., Rush Medical College, Chicago; (c) the general practitioner of medicine, Arthur [illegible], M.D., Milwaukee; (d) the layman, Wilfred S. Reynolds, Executive Secretary Council of Social Agencies, Chicago. The addresses will be followed by discussion.

Afternoon Session: A symposium on "Hospital Service for the Negro Population." (a) "Hospital and Out-Patient Facilities Which Will Afford Adequate Care of the Sick," Peter M. Murray, M.D.; (b) "Provision for Adequate Facilities for the Training and Education of Colored Medical Students," Basil C. C. Harvey, M.D., University of Chicago; (c) "Provision for Adequate Facilities for the Training and Education of Colored Nurses," Adda Eldredge, Director Bureau of Nursing Education, Wisconsin. The addresses will be followed by discussion.

Institutes and Special Courses

California: During the fall semester, two series of Senior students' vocational conferences were conducted under the auspices of the Northern League of Nursing Education. Ten lectures were given in each series.

The object of the conferences, which are conducted annually, is to interest the student in nursing organizations, to give her a comprehensive view of the fields of nursing open to her after graduation, to indicate to her the importance of advanced courses procurable both within and without the State, and to stimulate her to continue her education thereafter.

In San Francisco, the lectures were given in the auditorium of Mt. Zion Hospital School of Nursing with eleven schools participating; in Oakland, in the auditorium of Providence Hospital School of Nursing with seven schools participating.

Each series of lectures was opened with a stimulating address on "Advanced Courses" given by Miss Urch, Director of Nurses at Highland Hospital, Oakland. "Nursing in Foreign Fields" was interestingly portrayed by Eva Gregg, who was the second nurse in North China and who was later one of the group which was instrumental in incorporating the word "nurse" in the Chinese language. Chief nurses from the visiting nurse associations and city departments of public health told of the work being done in these branches of nursing; "Private Duty Nursing" was presented by a representative of the American National Red Cross from the Pacific Branch office, and "Navy Nursing" by Clare L. DeCeu, Assistant Superintendent of the Navy Nurse Corps. Edith S. Bryan, Assistant Professor of Public Health Nursing at the University of California, and Mary M. Pickering, President of the California League of Nursing Education and Assistant Professor

of Nursing Education at the University of California, talked on "University Courses." The conferences were concluded with a discussion of "Nursing Legislation" and "Nursing Organizations." Anna C. Jammé, Director at Headquarters of the California State Nurses' Association, discussed the former and then introduced Janet Geister, Director at Headquarters of the American Nurses' Association, who delighted the students with her presentation of the subject of "Organizations." Miss Geister's talk was a most happy conclusion of the series of lectures and most opportune in that it presented to the student of today the problem of changing conditions which must be met by the graduate nurse of tomorrow. Los Angeles.—An institute for nurses, under the auspices of the Southern Branch of the California League, was held January 15–17, with the following program:

January 15, 8 p.m. Students' Session, Mary Bruce, Director of Nurses at the Children's Hospital, presiding. Address of Welcome, Neva Hayes; "The Psychology of Well Being," Dr. Frederick P. Woellner; "The Need of University Education for Professional Women," Frances Fraser, Dean of Women, Riverside Junior College.

January 16, Morning Session, Ethel Swope presiding. Program conducted by the personnel of the Los Angeles County Health Department.

Afternoon Session, Hazel Grant Kershaw, Director School of Nursing, Methodist Hospital, presiding. "Showing the Way to Student Self-Development," Isabell Fothergill Smith; supervisors' symposium—"The Supervisor as a Teacher," Eva Hatterline; "Pediatrics Case Study," Thelma Hartman; "Results of Classroom Teaching and Ward Supervision on the Patient," Myrtle Childerhose; "Relationship of the Supervisor to the School of Nursing," Gladys Pease.

January 17, Morning Session, Gertrude Spanner, Director of Nurses, Bishop Johnson College of Nursing, presiding. "Principles of Teaching," Prof. Frank C. Touton; "Reciprocal Relation of Theory and Practice Teaching," Mary Edgar.

Afternoon Session, Nellie Porter, Bureau of Registration of Nurses, presiding. "Principles Underlying Practice Teaching," Prof. C. C. Crawford; Demonstration, "Prophylactic Methods in Control of Communicable Diseases," Edith Pilant.

Illinois: Chicago.—An Institute for Members of Boards of Directors of Hospitals and Public Health Nursing Organizations will be held at the Palmer House, Chicago, February 17. The preliminary program is as follows:

Morning Session, 9.30, "Education of the Nurse from the Point of View of Public Health Nursing," Edna L. Foley, Superintendent, Visiting Nurse Association of Chicago; "The Value of Experience in Hospital Social Service to the Student Nurse," Ruth Emerson, Director of Social Service Department, University Clinics, University of Chicago; "The University and Nursing Education," Clarence S. Yoakum, Ph.D., Dean, School of Liberal Arts, Northwestern University, Evanston; "Nursing and the Community," Haven Emerson, M.D., Professor of Public Health Administration, Columbia University, New York. Discussion.

Luncheon, 12.30, speaker to be announced.

Afternoon Session, 2 p.m., symposium—"Economic Aspects of Nursing Education and Nursing Service"—from the point of view of the hospital executive, Christopher Parnall, M.D., Medical Director, Rochester General Hospital, Rochester, N. Y.; address, topic to be announced, Edwin R. Embree, President, Julius Rosenwald Fund, Chicago; from the point of view of a principal of a school of nursing and director of nursing service (the need for cost studies to determine the cost of nursing education as distinguished from that of nursing service), speaker to be announced. Discussion.

Dinner, 7 p.m., joint dinner with Council on Medical Education and Hospitals of the American Medical Association, speaker, Dr. Robert Maynard Hutchins, President of the University of Chicago.

State Boards of Examiners

Georgia: An examination for graduate nurses will be held April 9–10, in Atlanta, Augusta, Macon and Savannah, assuming there will be a sufficient number of examinees to warrant. Application should be made to Jane Van De Vrede, Secretary of the State Board of Examiners of Nurses for Georgia, 131 Forrest Avenue, N. E., Suite 12, Atlanta.

State Associations

Maine: At the last annual meeting of the Maine State Nurses' Association, held in Bangor, January 3 and 4, the following officers were elected: President, Louise P. Hopkins, Bangor; vice presidents, Mrs. Theresa R. Anderson, Augusta, and Eleanor Campbell,

Portland; secretary, Mary I. Collins, State Hospital, Bangor; treasurer, Mrs. Lou. S. Herne, Portland. Great regret was expressed for the death during the past year of Hannah F. Clapp, a charter member of the Association, who had been secretary of the state and local Red Cross committees for eleven years. Miss Clapp had also served on the Board of Registration for Nurses of Maine. She was Assistant Superintendent of the Eastern Maine General Hospital for twenty-nine years.

Minnesota: At the January meeting of the Board of Directors of the MINNESOTA STATE REGISTERED NURSES' ASSOCIATION, it was voted to pay three cents per capita additional to the American Nurses' Association to make up the increase for the International Council dues, an item of $84, for 1930. The chairman of the Ways and Means Committee, Kathryn McGovern, reported that as a result of the sale of Christmas cards the State Association made a profit of over $700. Dora M. Cornelisen, Secretary of the Association for seven years, and now Field Representative for the *Journal*, was guest of honor and told of her work since leaving Minnesota. The Magazine Committee reported that the business of issuing the *Minnesota Registered Nurse* had been so successful the first year there is a balance left to begin 1930, and the magazine will continue. The General Secretary reported that the membership has increased to over 2,800. The Relief Fund Committee reported that $2,624 was contributed during 1929 to the Relief Fund.

Nebraska: Phoebe M. Kandel has resigned her position with the Department of Public Welfare. Miss Kandel did notable work for the schools of nursing of the state during her term in office. About February 1, Miss Kandel will become associated with Creighton University, Omaha. She will teach two courses offered for graduate nurses: (1) the "Principles of Teaching;" (2) "Methods of Supervision as Applied to Nursing Education." These classes will be given on Friday afternoons and Saturday mornings, in order that nurses holding positions may take advantage of them.

New Hampshire: The quarterly meeting of the GRADUATE NURSES' ASSOCIATION was held December 11, at the Nurses' Home of the Elliot Hospital, Manchester. Sectional groups held meetings in the morning and a general meeting was held in the afternoon, 125 in attendance, with an address by Dr. Ralph O. Clock of New York on "The Use of Vaccines," with a demonstration of methods. The State League discussed the educational requirements of applicants to schools of nursing. Grateful acknowledgment was made of a gift of $335 to a sick nurse by the Graduate Nurses' Association, several alumnae associations, and many individuals.

District and Alumnae News

Connecticut: Hartford.—At the annual meeting of the HARTFORD HOSPITAL ALUMNAE ASSOCIATION, held December 12, the following officers were elected: President, Agnes Hamilton; vice presidents, Edith Davis, Caroline, Hauser; secretary, Carrie Taylor; treasurer, Marion G. Gledhill. Chairmen of committees are: Finance, Irene Muller; Ways and Means, Barbara Di Lorenzo; Social, Thelma Cullom; Membership, Mae Sabin; Bulletin, Mrs. Lucy Hodges Woodson; Program, Agnes Post. Much thanks is due Laura Brownell, retiring president, for her coöperation with the officers and members during the three years of her helpful, willing service.

District of Columbia: Washington.—GEORGE WASHINGTON UNIVERSITY HOSPITAL ALUMNAE ASSOCIATION met on December 2, with a good attendance. Seniors and staff nurses were invited. Two students, Miss Graham and Miss Erbe, gave a demonstration of hypodermoclysis. An article was read from the *Journal* on "New Treatment of Enteritis of Tuberculous Patients." Miss Poindexter read an article on "Insurance for Nurses, the Harmon Plan." The New Year's dance was postponed because of the death of one of the members.

Georgia: Atlanta.—At the State convention, the FIFTH DISTRICT reported a total of 508 members for 1929, with a loss of some 7 per cent of this number through the formation of the new Eighth (Congressional) District, in September. Meetings have been held bimonthly, in Atlanta, and contributions have been made to the Bordeaux Memorial Fund, A. N. A. Relief, to the Grading Plan and to State Headquarters. The following officers were elected at the October meeting: President, Lillian Alexander; vice presidents, Minnie Bass, Mrs. J. F. Hawthorne; secretary, Mrs. Ralph Pope; treasurer, Blanche Sims. WESLEY MEMORIAL ALUMNAE ASSOCIATION'S annual report indicates interest and enthusiasm, largely attributed to the success of the Association in publishing its own medium the *Alumnae Nightingale*. A library for the new Florence Candler Harris Memorial Nurses'

Home is being furnished. This library has been dedicated to Mrs. Alberta Dozier Williamson, former superintendent of nurses and an honorary member of the alumnae. The 1930 officers are: President, Sallye O'Bannon; vice president, Dorothy Fowler; corresponding secretary, Lois Taylor; recording secretary, Lucile [illegible]; treasurer, Willie Lee Tennent. PIEDMONT HOSPITAL ALUMNAE ASSOCIATION, organized in 1909, has seventy-nine active members. It has its own relief funds, with $1,480 in the treasury, October 31. Financial aid has been given members; all loans are being repaid. The Association has lost two members by death the past year. The Association has contributed to the upkeep of State Headquarters, to the Bordeaux Memorial Fund and to other things. The hospital registry does not call for duty any Piedmont nurse not a member of her alumnae. ST. JOSEPH'S INFIRMARY ALUMNAE, organized in 1908, has 107 enrolled members, with an increase of twelve over last year. The alumnae contributes $30 per year (for five years) to the Grading Committee and has also contributed to the Bordeaux Memorial, to State Headquarters and other worthy causes. Among other activities the alumnae has refurnished the dining hall used by graduate nurses. The officers for 1930 are: President, Peggy Brooks; vice presidents, Neta Bohanon, Mrs. J. H. Harrison; secretary, Harriet Sherman; treasurer, Catherine Flynn. GEORGIA BAPTIST HOSPITAL ALUMNAE, in addition to regular monthly meetings, had literary and musical programs. The speakers have included a representative from an insurance company, who discussed investments for nurses; another from a steamship company, who explained possibilities of nurses' tours to Europe, etc. Free service to the amount of $438 was given graduate nurses, $86 to the relatives of nurses, and $128 to student nurses, by alumnae members the past year. Lillie Miller is president. DAVIS-FISCHER ALUMNAE maintains a loan fund available to members, with a balance of $[illegible], October 31. There are sixty-four active members. To serve in the hospital, a nurse must be an alumnae and a registry member. Members in good standing are given a discount for nursing and hospital service. The officers are: President, Mary [illegible]; vice president, Caroline [illegible]; secretary, Alice Thompson; treasurer, Mrs. George [illegible].

GRADY ALUMNAE ASSOCIATION holds regular meetings, the last Tuesday in every month, a special program being presented at each meeting. The Association is studying *Nurses, Patients and Pocketbooks*. Janie Candlish recently gave an interesting report of the meeting of the I. C. N. The alumnae maintains a loan fund, a Thanksgiving offering being made annually for this purpose. Contributions have been made to the Relief Fund, the Bordeaux Memorial Fund, the Grading Committee, and to State Headquarters. The Association sends annually a student to the State Association meetings, in addition to a delegate from the alumnae. A water oak was planted on the Stone Mountain Highway by the alumnae. A member serving in China was presented with a book, in addition to alumnae dues. A Christmas basket is provided a needy family each year, and floral offerings are sent in cases of illness and death to members and their relatives. The officers for 1930 include: acting president, A. B. Fosbeck; vice president, Connie Bailey; secretary, Mrs. Alma Lewis Wilson; treasurer, Mrs. J. F. Hawthorne. ATLANTA HOSPITAL ALUMNAE ASSOCIATION has as officers: President, Mrs. Leila C. Peyton; secretary, Katie Payne; treasurer, Betty Ware. Macon. —The report of the SEVENTH DISTRICT ASSOCIATION, submitted at the Annual State Convention, indicates a splendid increase in membership, total of which is 154. The District alternates the holding of monthly meetings in Macon and Milledgeville, and attendance is always good. Contributions were made to the Grading Committee, the Bordeaux Memorial Fund, to the District Nurses' Relief Fund and to other things. Officers are: President, Dora Kershner; secretary, Minnie B. Wood; treasurer, Ann Rogers. MACON HOSPITAL ALUMNAE has sixty-one active members. A contribution was made to State Headquarters. Officers are: President, Mattie Lou Banks; vice presidents, Ruth Smith, Mrs. Fred Webb; secretary, Leila Walldorf; treasurer, Arie Robbins. MIDDLE GEORGIA SANITARIUM ALUMNAE has twenty-four members. Flowers are sent to members who are ill. Contributions were made to the Relief Fund and the Grading Committee. Officers are: President, Esther Robinson; vice president, Alice Butler; secretary, Erma Pollock [illegible]; treasurer, Marion Smith. OGLETHORPE PRIVATE INFIRMARY ALUMNAE, organized in 1925, has ten members. A contribution was made to Headquarters. The organization has a [illegible] [illegible] fund. Officers are: President, Mary [illegible]; vice president, [illegible] [illegible]; secretary-treasurer, Mabel Johnson. Milledgeville. —GEORGIA STATE SANITARIUM ALUMNAE, organized in 1915, and reorganized in 1925, has twenty-three active members. Contributions have been made to Grading, to relief and social

service. Its activities include programs at each meeting, study work, entertainment, etc. *Nurses, Patients and Pocketbooks* was reviewed last year. Officers are: President, Carrie M. [illegible]; vice presidents, Minnie Champion, [illegible] Layfield; secretary, Vashti Durden; treasurer, Vallie Badger. Rawlings Sanitarium has an enrollment of thirty, with two new members and four reinstated. Activities have included furnishing a room in the Sanitarium where three nurses have been cared for. A contribution was made to State Headquarters. Officers are: President, Mrs. Sarah P. English; vice president, Mrs. Mae M. Jones; secretary, W. J. Davis; treasurer, Cora Lee Harrell.

Iowa: Des Moines.—The Seventh District's annual meeting was held following a dinner at Younker's Tea Room. The program consisted of committee reports and the president's address. The new officers are: President, Amanda Anderson; vice presidents, Mary Ella Chayer, Mae Rudig; secretary, [illegible]; treasurer, Dorothy Bixler. Dubuque.—Finlay Hospital Alumnae held its annual meeting in December. The following officers were elected: President, Ida Kammueller; vice president, Eunice Brackett; secretary, Edna Kupferschmidt; treasurer, Laura Stratman. Fort Dodge.—The regular annual meeting of Eighth District was held, January 8, at St. Josephs' Mercy Hospital, with forty members present. Reports of the secretary and treasurer showed eighty-one members in good standing. Officers elected are: President, Grace Scheerer (reelected); vice president, Hilda Olson; secretary, Marguerite Mitchell; treasurer, Lillian Frommelt. Committee chairmen are: Relief Fund, Mrs. Mae Taylor; Publicity, Pearl Swasond; Credentials, Anna Powers; Entertainment, Vera Gow; *Journal* subscriptions, Mrs. Emma [illegible].

Michigan: Mary C. Wheeler, who has been General Secretary of the Michigan State Nurses' Association, resigned from that position January 1. Olive Sewell is Michigan's newly appointed General Secretary. Detroit.—At the annual meeting of the Detroit District, held January 8, Grace [illegible] was reelected president; Ruth Bruner, secretary, and Ethel [illegible], treasurer. Alice [illegible] of Indianapolis has recently come to the city to direct the nursing service of the Children's Fund of Michigan. Dr. [illegible], noted psychologist of Vienna, conducted courses in mental hygiene, during the month of January, through the courtesy of the Children's Fund of Michigan. The courses were open to nurses, social workers, teachers, and parents.

Minnesota: St. Paul.—The Public Health Section of Fourth District was delightfully entertained by the Tri-State Telephone and Telegraph Company, on January 8, at the Cedar Exchange, the largest in St. Paul. The forty-five nurses were escorted through the tunnels; the operating room, where they watched the marvellous manipulating of the wires in making connections, and the social and welfare departments.

Missouri: Springfield.—The Fourth District invited the seniors of the schools of the city to its Christmas party, held at the Y. W. C. A. on December 14. The Baptist Hospital Alumnae have elected the following officers for 1930: President, Rosella Brown; vice president, Millie Taylor; secretary, Maude Griter; treasurer, Nana May Wilson. St. Louis.—A postponed meeting of the Third District was held, October 28, so as to hear the reports of the delegates to the State Convention. At the following meeting, November 18, it was a privilege to have Dora M. Cornelisen, Field Representative of the *American Journal of Nursing*, present. The new addition to the Missouri Baptist Hospital was dedicated recently. The new Deaconess Hospital suffered damage by fire, caused by the upsetting of boiling tar. The Martha House of St. Mary's Hospital was dedicated recently and was open to the public for three days.

New Jersey: Atlantic City.—District 6 held the annual meeting on January 6, at the Cumberland hotel, Bridgeton, with the Bridgeton nurses as hostesses. Officers for the year are: President, M. Christine Liggett; vice presidents, Lula C. Suddoth, Mrs. Grace Endicott; secretary, Anna Wetherill; treasurer, Mathilda May.

New York: Binghamton.—District 5 held its annual dinner meeting on January 6, in the Y. W. C. A., Jeannette B. Salmon presiding, and forty members in attendance. Officers elected are: President, Ida J. McAfee; vice presidents, Margaret Wilson, Mrs. Rita Ford Huener; secretary, Ethel A. Thornburn; treasurer, Noraline Castner. New York.—At the annual meeting of the Alumnae Association of the New York Post-Graduate School for Nurses, held January 7, the following were elected: President, Annie McDougall; secretary, Sarah Mandigo; treasurer, Agnes M. B. Williams. Rochester.—The League of Nursing Education (Section 4) has elected as officers: President, Mary M.

Anderson; treasurer, Irene Lange. Chairmen of committees are: Program, Helen Wood; Credentials, Jessica Heal; Nominating, Olive Anell. The Private Duty Section of District 2 meets bi-monthly at the Club House, with a good attendance. Mary Anderson is chairman. The Public Health Nursing Association has changed its headquarters from the Chamber of Commerce to 130 Spring Street, a spacious old mansion which gives more room for the work and also a more central location. St. Mary's Alumnae Association held its annual meeting, January 6, at the Nurses' Home. Seventy-seven were present. Anne McKevitt was elected president. The Rochester General Hospital Alumnae Association held its annual meeting at the General Hospital, January 6. Katherine Gray was elected president.

North Carolina: District 1.—The outstanding feature of the December meeting was an address by Lula West, State Educational Director, on the "Minimum Requirements for Schools of Nursing." Miss West explained in detail the "twenty points" required by the North Carolina Standardization Board for accredited schools. Belle Campbell, Chairman of the Christmas Cheer Committee, reported the preparation of twenty-three substantial, attractive Christmas baskets for sick nurses. Five new members were admitted to the Association. District 2.—The Spirit of Christmas was in control of the December meeting of the Winston-Salem nurses. Each one arrived bearing a contribution of groceries to be turned over to the Salvation Army; a generous supply of fruit and candy was sent to the Children's Home. A check for $10 was given to the Y. W. C. A. and one for $25 to a sick member of the Association. Subscriptions to the *American Journal of Nursing*, the *Saturday Evening Post*, and the *Ladies' Home Journal* were sent to the student nurses in the three local hospitals. One new member was admitted. District 3.—The annual meeting was held in December, and the following officers elected: President, May McLaughlin; vice presidents, Goldie Howell, Anna Davis; secretary, Pearl Flannagan; treasurer, Sadie McDonald. Christmas greetings and generous checks were sent to the sick members of the District. District 4.—Agnes Gray, Superintendent of Nurses, Clinic Hospital, Greensboro, read an instructive paper on the "Work of the Grading Committee." District 5.—The League Calendars were displayed, and a talk on the work of the League of Nursing Education was made by Josephine Hull, Superintendent of Nurses, Watts Hospital, Durham. Much interest was expressed and many calendars were bought. Four new members were accepted. District 6.—Fourteen new members have been admitted to the District. The officers are especially interested in the reorganization of three alumnae associations, thus bringing them into the District, State and National associations. District 7.—The Fayetteville nurses were most fortunate in having Miss Wu, President of the Chinese Nurses' Association, as the speaker for their December meeting. Miss Wu's address was most interesting and instructive. This District reports twenty-two new members. District 8.—The Wilson and Goldsboro nurses motored to Kinston, where the December meeting was held. The President, Marie Farley, in a brief address emphasized the value of membership in the Nurses' Association. Alice Hodges spoke on "What I Get Out of the Nurses' Association." Dr. Charles Mangum contributed an interesting paper on "The Trained Nurse." District 9.—Elizabeth Williams, Superintendent of the tuberculosis sanatorium, gave an instructive talk on "Nursing Tuberculous Patients." Membership dues and checks were sent, with Christmas greetings, to two sick nurses. A valuable book was donated to the students' library, James Walker Memorial Hospital.

Ohio: Akron.—Judge Benner was the speaker at the annual meeting of District 1, held at the Woman's City Club, January 14. Cincinnati.—The regular monthly meeting of District 8 was held at Bethesda Surgical Hospital on January 22. Dr. Wilsbach gave an interesting talk on "Health Problems." The regular monthly meeting of the Educational Section of District 8 was held on January 27 at the Jewish Hospital. The program was given by the science teachers of District 8 nursing schools.

Oregon: The Dalles.—At a meeting of the Dalles Hospital Alumnae members and local nurses held at Hotel Dalles, recently, District 2 was reorganized, consisting of Hood River, Sherman and Wasco Counties. Mrs. Eugenia Hyman of the Dalles Hospital introduced Jane Gavin of Portland, president of the Oregon State Graduate Nurses' Association, who was honor guest. Following the no-host dinner, a business session was held, when the following officers were elected: Martha E. Jaffee, president; Mrs. G. N. Gessman, Ethel J. Woodman, vice-presidents; Mildred Beck, secretary; Lydia Eilers, treasurer; Mabel Spinning and Marian Lord,

directors for a three-year term; Charlotte [illegible] and Mrs. Winifred W. Hicks, directors for a two-year term; Mabel Dupree and [illegible] Nixon, directors for a one-year term.

Pennsylvania: Allentown.—The regular meeting of the ALUMNAE OF THE SACRED HEART HOSPITAL was held December 17. The following officers were elected: President, Helen M. Duffy; vice president, Caroline Long; secretary, Eva D. Hahner; treasurer, Della Niland. A check for $200 was given as the first payment of the Alumnae pledge of $2,000 to the hospital campaign. Philadelphia.—The ST. LUKE'S AND CHILDREN'S HOMEOPATHIC ALUMNAE had an unusually large attendance at their December meeting. Two new members were admitted and two sick members were remembered with Christmas gifts. The ALUMNAE ASSOCIATION OF THE PROTESTANT EPISCOPAL HOSPITAL held its annual meeting, January 7, in the Nurses' Home. The following officers were elected: President, Anna B. Behman; vice presidents, Frances L. Gooden, Susan J. Hay; secretary and treasurer, (Mrs.) Ethel K. Griffith. It was decided to have a copy of the letter "Are You Registered in the State of Pennsylvania?" sent to all graduates of the school who have not registered since graduating. Pittsburgh.—The PITTSBURGH LEAGUE OF NURSING EDUCATION met at the Nurses' Club, January 8, when Dr. William T. Root, of the University of Pittsburgh, discussed "The Relative Order of Attention and Its Application to the Teaching of Hygiene and Health." The election of officers was also held and the following were reelected: Chairman, Ruth Bower; vice chairman, May Hinchy; secretary-treasurer, Helen Pratt; director, Sister Mathilde. The November meeting was held at the Nurses' Home of the Western Pennsylvania Hospital, where the members were very nicely entertained by Miss Bower and her staff. The student nurses gave a play entitled "Florence Nightingale." The senior students of the various hospitals were invited and many of them attended.

Texas: El Paso.—DISTRICT 1 has followed the suggestion of the State Association and given a subscription to the *American Journal of Nursing* to the Public Library, the High School Library and the Y. W. C. A. Christmas baskets were distributed to all sick nurses in hospitals, homes and sanatoria. Galveston.—DISTRICT 6 held its regular meeting at St. Mary's Infirmary on January 6. The senior classes of St. Mary's and University of Texas Schools of Nursing were guests of the Association. A. Louise Dietrich, State General Secretary, discussed state and national activities of the nurses' associations and gave her impression of the I. C. N. meeting at Montreal in a very interesting and inspiring way. When Miss Dietrich had finished her talk, the question in the minds of many nurses, "Where do all those dues go to?" was well answered.

Wisconsin: Milwaukee.—The Committee on Student Activities for the Biennial Convention would like to be advised as to the number of schools planning to send student nurses to the Convention and the number of students who are planning to go so that arrangements for them may be made accordingly. Address: Helen W. Kelly, 88 Prospect Avenue, Milwaukee.

Deaths

Kate Byrne (class of 1911, St. Bernard's Hospital, Chicago), on December 26, 1929, at St. Joseph's Mercy Hospital, Ft. Dodge, Iowa, following a year's illness from cancer. Miss Byrne was buried in the Catholic cemetery, Gilmore City, with military honors, having served during the World War at Camp Dodge. After graduation, Miss Byrne did private duty in Chicago for two years and later in the vicinity of her home, Gilmore City, until she entered service. After discharge from the Army, Miss Byrne began practice in Ft. Dodge, where she remained until the time of her death. She was always an active worker in the nurses' organizations and served as president of Eighth District for several years. During her long illness she never lost interest in anything pertaining to her profession.

Elizabeth Thomas Childers (graduate of the West Side Hospital, Chicago), on November 18, 1929, of heart disease, an aftermath of scarlet fever which she contracted from a patient. Miss Childers had a wide and varied experience in Public Health Nursing, and had been on duty at various times in nearly the entire rural area of Cook County. Her will power and physical endurance, even when ill, was the wonder of her friends. Her fine education and her skilled labor made her a favorite in the camps during the war. She gave her entire self to her profession. She was intolerant of mediocrity because she believed it was unnecessary.

Rose Connell (graduate of Bellevue Hospital, New York), on December 11, 1929, at Denver, Colo., after a lingering illness. After graduation, Miss Connell came back to Chicago to take up infant welfare work, and was with the Society for a long time. Later she took the Civil Service examination for rural nursing and gave devoted service to this Division for more than a year. She had a lovely personality, and was a wonderful soldier when obliged finally to give up her work on account of illness.

Julia Elizabeth Morton (class of 1898, Philadelphia Orthopaedic Hospital and Infirmary for Nervous Diseases, Philadelphia), on November 29, 1929, at her home, Middletown, Del., of angina pectoris. Miss Morton was a fine woman, an excellent nurse and much beloved by all who knew her.

Mrs. Ellen Telfer (class of 1913, Iowa Methodist Hospital, Des Moines), on December 18, 1929, at Iowa Methodist Hospital after an illness of many weeks. Funeral services were at Gilmore City, her home. Except for a time when she served as registrar for the Seventh District registry and for a short time when she was associated with the local Red Cross during the War, Mrs. Telfer had not left the ranks of the private duty nurses. She was active in organization work and was serving as president of her Alumnae Association and as chairman of the Private Duty Section of the State Association at the time of her death.

Martha Cosby (class of 1908, West-Ellis Hospital, Chattanooga, Tenn.), on January 1, of pneumonia, at her home, after a few days' illness. Miss Cosby had always been an active member in the nursing organizations, and she will be missed from the meetings as well as in the nursing field.

Mrs. George Johnson (Rosa Farmer, class of 1921, Baroness Erlanger Hospital, Chattanooga, Tenn.), at Halls, Tenn., on January 1, from tuberculosis. Mrs. Johnson had never been able to do nursing, having spent nearly all the time since her graduation in sanitaria. She was removed to her home from Tucson, Arizona, in November.

Mrs. Iva Blair Meyers (class of 1914, Good Samaritan Hospital, Lexington, Ky.), on December 16, 1929. Mrs. Meyers served overseas with Base 40, better known as the "Barrow Unit," during the World War. She was with the Veterans' Bureau Hospital, Alexandria, La., and at Fort Thomas, afterwards, resigning in 1923. Full military honors were accorded Mrs. Meyers' burial.

Prize-winning Stories of Social Work

THE Harmon Foundation of New York and the Social Work Publicity Council have recently awarded three prizes for the best true stories of social work. Dr. Eva Reid, Chief of the Psychiatric Clinic of the University of California Society for Mental Hygiene, received the first award of $300 for her article "Fighting Through." This describes the experiences of an orphan, who has difficulty in adjusting herself to contacts with institutional life and with the outside world.

An award of $200 went to Harold J. Matthews, Secretary of the State Conference of Social Work, at Columbia, Missouri, for his article, "Are Old People Human?" He describes the inhuman treatment of the aged in an almshouse, which is a composite of institutions he has known.

Lillian J. Johnson, Director of Child Welfare in Nebraska, received $50 for her story of "Lithuanian Steve," his American wife and their child.

About Books

Handbook on Venereal Diseases for Nurses and Others Engaged in the Routine Treatment of These Diseases. By W. Turner Warwick, F.R.C.S. 221 pages. Illustrated. Faber and Gwyer, Ltd., London, 1928. Price, 6/–.

A CONCISE, comprehensive, little volume containing not alone the modern scientific theory and practice of venereal-disease treatment, but a résumé of the history of the diseases. Dr. Warwick has culled from many clinics and hospitals the best and accepted methods of the various institutions.

The first part of the book is concerned with the history of the diseases, and with the general and sociological aspects of the problem. Considered in these chapters are: (1) "Venereal Disease in the Community," which discusses the nurse in relation to the venereal diseases; the incidence of the diseases; the damage done by these conditions; and their cost to the community; (2) "The Prevention of the Venereal Diseases," which is treated from the standpoint of legislative measures for the prevention of the diseases; societies for combatting them; public education; and prophylaxis and treatment centers; (3) "Duties of a Nurse toward Patients with Venereal Disease" are outlined with regard to precautions to prevent the spread of the infections; to the attitude of the nurse to the patient; and—most important and timely—the medico-legal aspects of the problem.

Unfortunately for us, these chapters are written from the standpoint of British law and British social conditions and so are of little practical value; notwithstanding, they are a distinct contribution to the literature on this subject, and stress the invaluable service which may be rendered by a properly qualified and interested nursing profession. The attack on the problem from this angle has not been sufficiently emphasized either in the literature or in the lecture rooms of the schools of nursing in this country. The author makes a strong and urgent plea for the education of the nurse along these lines which may be heeded with profit by all nations.

The rest of the book is concerned with diagnosis and treatment. Recognizing the work as a "Handbook for Nurses," there is too much stress on the details, manner, and selection of treatment, a thing solely for the physician to decide and beyond the province of the nurse.

It is to be regretted that Dr. Warwick uses the term "venereal disease" as though it were an entity, thus emphasizing the idea already in the minds of many nurses and social workers that there is such a thing as "venereal disease"; rather than the idea that, included in the term, are two separate and distinct diseases of widely differing causes, symptoms, effects, and treatments, and nowise related to each other or lending themselves to similar handling.

The author misses a great opportunity by paying such scant attention to skin diseases in relation to syphilis, a subject woefully neglected in

the usual nursing school curriculum. Syphilis being the great imitator of all diseases, and especially so with respect to other cutaneous lesions, deserves far more space than has here been allotted to it.

The illustrations of the conditions could well have been omitted. They have no value in a work of this kind and, since many of them are poor and misleading, an inexperienced person would get a distorted conception of the appearance of the several conditions if he allowed himself to be influenced by these illustrations of them.

A good index assists materially in the use of the book.

ANN DOYLE, R. N.

New York.

COMMUNICABLE DISEASES FOR NURSES AND MOTHERS. By Albert G. Bower, M.D. and Edith B. Pilant, R.N. 327 pages. Illustrated. W. B. Saunders Company, Philadelphia, 1929. Price, $3.

THIS book, prepared especially for student nurses, has already been greeted with interest by instructors and lecturers on communicable diseases.

For some time we have looked for a book which would embody the following contents: first, the knowledge of the source and characteristics of the various diseases, together with the nursing care of the patient who has fallen a victim to any one of them whether in an institution or a private home; second, an outline of aseptic technic which would include helpful illustrations to demonstrate aseptic technic applied to medical cases, for we have had surgical asepsis emphasized over a long period of years, but, until recently, relatively little emphasis was placed upon medical technic applicable to the wards of general hospitals and the home, as well as to a communicable-disease hospital.

Communicable Diseases for Nurses aims to meet these needs. The authors have included all of the diseases named in the annual report of the Committee of the American Public Health Association on "Standard Regulations for the Control of Communicable Diseases." A very thoughtful discussion of the forty-two diseases listed in this report is found throughout the 310 pages of the forty-five chapters into which the text has been divided.

The chapter on "Medical Asepsis" contains a detailed outline of procedures for the nurse who is handling a communicable-disease patient, and careful explanation of each procedure is made so this technic could be applied in a home, or the wards of a general hospital, or the wards of a communicable-disease hospital.

However, an important omission in this chapter is noted; namely, the history of the development of aseptic technic in Paris, the experiment with medical asepsis in the celebrated Pasteur Institute in 1890.

The illustrations concerning aseptic technic are very good. We all admit differences of opinion in the application of aseptic technic principles, but these illustrations will be most helpful in those remote sections of our communities where instructors and supervisors are obliged to work out their own solutions in their isolation wards.

It is logical to have the beginning chapters on aseptic technic and the care of communicable-disease patients in the home, for in these chapters the authors accentuate the important fact that the prevention of one disease is a protection against all of the forty-two diseases discussed in the succeeding pages.

The chapters covering the individual diseases are well organized and the material clearly presented. The

etiological and the symptomatic factors presented in connection with each disease make the book particularly valuable both as a reference and a textbook for students in general hospitals who have so little experience with communicable diseases or, rather, how so little emphasis placed on this vital phase of nursing.

The authors, realizing these needs, have aimed to give the nurse, both graduate and student, a detailed picture of the course of each disease with the appropriate medical and nursing care.

One regrets that the valuable summaries found on the last pages of the discussion of diphtheria, scarlet fever, whooping cough and a few others, are not given, for ready reference, under each disease.

The chapter on tuberculosis might have been considerably more helpful had the importance of *early recognition* been stressed, and had a rest régime been outlined. It is unfortunate that so many authors present only the so-called classical symptoms of hemorrhage, emaciation, cough, expectoration, etc., whereas other factors and earlier symptoms, if recognised and considered, might result in the prevention of many disasters.

The chapter on trachoma is too limited to be of any practical help for a nurse who faces many trachoma cases in her public health experience. Several good references might have been given on this important disease.

The few illustrations of various [illegible] are excellent. It would have been helpful to illustrate variola as well as varicella for differential [illegible].

The [illegible] is helpful, but could be [illegible] more so by the addition of [illegible] terms and words applied in the [illegible] of the communicable diseases.

[illegible]

The authors hope this text can also be of use among mothers. We do not question the need of such a book but this text is too technical for a laywoman's use, and should be emphasized as a text for nurses, which the title of the book implies.

The book, throughout all its pages, very properly emphasizes the rôle of the nurse in the prevention as well as in the nursing care of these diseases, and we welcome this presentation as another means of arousing greater interest in this much neglected phase of nursing.

ELIZABETH F. MILLER, R.N.
New York.

INFANCY AND HUMAN GROWTH. By Arnold Gesell, M.D. 418 pages. Illustrated. The Macmillan Company, New York, 1928. Price, $3.50.

IN the preface Dr. Gesell summarizes his studies on infancy and human growth as aiming

> to deal with early human growth at close range, by methods of systematic observation and of direct record. . . . Experimental biology and experimental medicine are gradually placing the phenomena of growth upon a firm basis of fact and at the same time they are dissolving the ancient distinction between mind and body by bringing the functional and structural aspects of growth into integrated relation.

Mental growth is much more difficult to measure than is the physical, but a glance at the total cycle of mental growth suggests close relations between the psychological and the biological aspects of developmental problems.

Comparative investigations, at periodic intervals, of infants showing great variation in reaction have been made and the results tabulated. From these results it has been possible for Dr. Gesell to make suggestions as to the course and patterns and rates of mental growth at various levels of

maturity, in normal and exceptional children. At the present stage of the method, the measurements must be regarded as approximations.

Throughout the investigations the emphasis is laid on normal aspects of infancy, and unusual growth complexes are discussed only to emphasize the normal aspects. The nutritional, environmental, and conditioning factors entering into the complex of growth have been generally discussed. Dr. Gesell has carefully observed and noted the characteristics of growth of the premature infant and of twins in relation to the normal infant. These he discusses at length and illustrates with specific observations from individual cases.

Heredity has been considered in Part III.

Comparisons of the developmental lives of golden eaglets and other forms of life are made with that of the human infant. Studies of growth potency in infant personality are noted and charted as to rate and patterns of development. Finally some clinical predictions of mental growth are made. The book makes more easily understood the various phenomena with which we are familiar, but which are not fully understood. Dr. Gesell's contribution is a scholarly one. The real student in all professions will more fully appreciate the changes noted in the course of this study and be better able to interpret their significance. LEROY A. WILKES, M.D.

New York

TEXTBOOK OF GYNECOLOGY. By Lynn Lyle Fulkerson, M.D. 842 pages. Illustrated. P. Blakiston's Son and Company, Philadelphia. Price, $9.

THIS book seems to have all the detail information that we search through many reference books to find in the compliment paid by a postgraduate nursing student to the *Textbook of Gynecology* written by Dr. Fulkerson.

The points which so impressed this student were the scope of material, the excellent bibliography, and the good organization of the subject matter. The work is a most comprehensive one, covering the essentials of both medical and surgical gynecology and gives much technical material in a clear concise fashion; the bibliography gives excellent source material that is both up to date and authentic; and there is clear-cut organization of subject matter, with good paragraph headings, splendid outlines, and a complete index.

However, medical criticism has been that the book is a compilation, rather than a real contribution, and that, although excellent bibliography is given, the detail recorded is not always given as fully nor as accurately as it might be. Certainly some of the illustrations bear out the latter criticism, for example, those of the various positions.

The format of the book is commendable for size, type, and quality of paper.

Because the strong points of the book are its scope and bibliography, it would seem that its best use for any library is that of a source book.

M. CORDELIA COWAN, R.N.

New York.

THE FACTS OF MODERN MEDICINE. By Francis W. Palfrey, M.D. 430 pages. D. Appleton & Company, New York. Price, $[illegible].

WHILE written for the lay reader, *The Facts of Modern Medicine* is in no sense a "family medical adviser." Its whole purpose is to present the facts of modern medicine in such a way that they are

[illegible]ible to the average reader, [illegible] also the intelligent one.

[illegible] book is planned in much the [illegible] fashion as the medical course for the medical student. At least the [illegible] third of it considers those biological [illegible] which are necessary as a [illegible] for the later discussion of [illegible], as well as for an appreciation of [illegible] human body and this living [illegible]. There is a short section devoted to methods of diagnosis and [illegible] therapeutics and finally the [illegible] half of the book consists of brief [illegible] of disease, following the [illegible] plan as to anatomical systems as [illegible] the chapters on anatomy and [illegible].

[illegible] the most interesting feature of [illegible] is its underlying philosophy [illegible] grants the layman the right to [illegible] more of modern medical [illegible] than he has been in the [illegible] having, and that, not with a [illegible] working self-cures, but because [illegible] can thereby live more intelligently. The author would do [illegible] those shreds and tatters of [illegible] which so many of us cling [illegible] to our medical beliefs.

[illegible], Chapter XVIII [illegible], in which the author [illegible] a conception of the medical [illegible] is neither magician nor [illegible] interesting. A reading of [illegible] would, in fact, be excel[illegible] for a first trip to the [illegible].

[illegible] chapter of the book is of [illegible] interest because it is [illegible] "Death, Considered [illegible]." While the author [illegible] death is an "awesome [illegible] also to consider it a [illegible], with few exceptions, [illegible] by the dramatic as [illegible]. The idea should [illegible] to many of us. [illegible], the whole book considers the subject of modern medicine as one involving quite natural processes. It should be of interest to the lay person who wishes to be intelligent in this field.

H. W. M.

[illegible]

An Explanation: The American edition of *Gynecology for Nurses and Gynecological Nursing* by Comyns Berkeley, M.A., M.D., published in England by Faber and Gwyer, London, and reviewed in the January *Journal* by M. Cordelia Cowan, is published in the United States by G. P. Putnam's Sons, New York, $2.50.

A Textbook of Anatomy and Physiology. By Jesse Feiring Williams, M.D. Third edition, revised 578 pages. 405 illustrations. W. B. Saunders Co., Philadelphia. Price, $2.75, including

Outline for Teaching Anatomy and Physiology. By Jesse Feiring Williams, M.D. Third edition. 16 pages. W. B. Saunders Co., Philadelphia.

As stated in the preface, this book contains the essentials of anatomy and physiology for students in the practical arts. Dr. Williams has presented the subject matter from a scientific and logical point of view—an approach so frequently lacking in elementary textbooks on this subject. Attention is given to the ontogenetic as well as the phylogenetic development of the human body. These introductions are stimulating to the student who wishes to further her investigations in the nature of this parallel development, as well as broadening to the general information of the average student in anatomy and physiology.

The first three chapters of the book are devoted to a presentation of the general plan and organization of the human body, the formation of the embryo and the structure and function of

the five groups of tissues. The remaining sixteen chapters are arranged according to the systems, and are as follows: three chapters on the skeleton, one chapter on skeletal muscle, three chapters on the nervous system, two on the circulatory system, one on the respiratory system, two on the digestive system, one on the reproductive system, one on the endocrine system, and one on the organs of special sense—this sequence is practical, and the contents of the chapters are very well developed. However, the arrangement of any text is of little consequence to many instructors who prefer to plan courses according to individual ideas on the subject.

The book is rich in illustrative diagrams, plates and charts, which aid the student in clarifying the detail of structure and function, regardless of the laboratory material at her disposal. The consideration of the growth and development of the human body from childhood gives to the student an idea of relationships other than those to be found only in the adult structure. Correlations are made with the abnormal through a presentation of congenital and disease conditions. Terminology consistent with B. N. A. (Basle Nomina Anatomica) would increase the scientific value of the book to the student wishing to refer to some of the advanced texts, or to the student who at a later date may specialize in this particular subject. In addition to the above situations, B. N. A. terminology is significant of direct relationship, in that the student is able to make rational associations rather than memorizing irrelevant detail. For example, quadriceps femoris (B. N. A.), meaning femoral muscle of four heads, is more accurate than quadriceps extensor femur (old terminology), meaning extensor of the femur, an action for which this muscle is not responsible. The glossary contains a number of clearly defined words, and is a convenience to the student.

The instructor will find valuable suggestions in the practical exercises and questions at the end of each chapter, while references for further study, which have been chosen from the author's wide experience, offer many possibilities for increasing one's information on anatomy and physiology and its related sciences.

The value of any outline such as accompanies Dr. Williams' text is one of relative importance. The suggestions for teaching the subject matter, as stated in the foreword of the outline, are definite and not inelastic. The time allowed for covering the material is a question, certainly, to teach adequately in sixty hours the content of such a course as outlined by the author, would be an impossibility if the information gained by the student were to be based on any association of ideas. The periods of fifty minutes each are divided into four parts, namely quiz and review, topics for discussion, demonstrations and the assignment for the next period. The demonstration might be used as brief guide for the formation of a laboratory course.

Finally, the value of any book on this subject, whether text or reference, should be based on the merit of its scientific approach, the quality of the subject matter, the clearness and richness of its illustrative material, and by no means least in consideration is the background of experience which Dr. Williams brings to the authenticity of the book. The above are points in favor of this textbook of anatomy and physiology.

Ella Best, R.N.

Illinois.

Official Directory

[illegible] Council of Nurses.—Sec., [illegible] Reimann, 14 Quai des Eaux Vives, [illegible], Switzerland.

[illegible] Journal of Nursing Company [illegible], 370 Seventh Ave., New York.—[illegible] M. Henderson, Milwaukee Chil[illegible] Hospital, Milwaukee, Wis. Sec., Stella [illegible], Children's Hospital, Boston. [illegible] Mary M. Riddle, care American [illegible] of Nursing New York, N. Y. Elsie [illegible], Baltimore; Sally Johnson, Boston; [illegible] Vaughan, St. Louis; Elisabeth [illegible], Washington, D. C.

[illegible] on the Grading of Nursing [illegible].—Director, May Ayres Burgess, [illegible] 370 Seventh Ave., New York.

[illegible] Nurses' Association.—Head[illegible], 370 Seventh Ave., New York [illegible] Clayton, Philadelphia General [illegible], Philadelphia, Pa. Sec., Susan C. [illegible], Children's Hospital, Philadelphia, [illegible] Jessie E. Catton, New England [illegible] for Women and Children, Dimock [illegible], Boston 19, Mass. Headquarters Dir., [illegible], 370 Seventh Ave., New York. [illegible] Private Duty, Chairman, [illegible], 2?3 E. Voris St., Akron, O. [illegible], Chairman, Effie J. Taylor, [illegible] Hospital, New Haven, Conn. [illegible], Chairman, Josephine E. Thur[illegible] Hospital, Cambridge, Mass. [illegible] Nursing Service. Chairman, [illegible], Bureau of Indian Affairs, [illegible] Interior, Washington, D. C. [illegible], Chairman, Carrie M. [illegible] Brigham Hospital, Boston. [illegible], Chairman, Marie Louis, [illegible], Plainfield, N. J.

[illegible] League of Nursing Educa[illegible], 370 Seventh Ave., New York [illegible] C. Burgess, Teachers [illegible] York. Sec., Stella Goostray, [illegible], Boston. Treas., Marian [illegible] Hospital, New York. [illegible] D. Gage, 370 Seventh Ave., [illegible]

[illegible] Organization for Public [illegible].—Pres., Mrs. Anne L. Hansen, [illegible], Buffalo, N. Y. Director, [illegible], 370 Seventh Ave., New [illegible]

[illegible] Robb Memorial Fund [illegible], Elsie M. Lawler, [illegible] Hospital, Baltimore, Md. [illegible] DeWitt, 370 Seventh Ave., [illegible]

[illegible] Division, American Nurses' Association.—[illegible], Edith Soule, State Dept. of Health, Augusta, Maine. Sec., Elizabeth Van Patten, 35 Elm St., New Haven, Conn.

Middle Atlantic Division.—Pres., Jane E. Nash, Church Home and Infirmary, Baltimore, Md. Sec., Marion Durell, City Hosp., New York.

Mid-West Division.—Pres., Mabel Dunlap, Moline, Ill. Sec., Grace Ross, 1415 St. Antoine St., Detroit, Mich.

Northwestern Division.—Pres. Mrs. Elizabeth Soule, University of Washington, Seattle, Wash. Sec., Katherine Leahy, University of Washington, Seattle, Wash.

Southern Division.—Pres., Annie M. Beddow, Norwood Hosp., Birmingham, Ala. Sec., Bernardine Bryant, 903 First Ave., Selma, Ala.

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Army Nurse Corps, U. S. A.—Superintendent, Major Julia C. Stimson, War Department, Washington, D. C.

Navy Nurse Corps, U. S. N.—Superintendent, J. Beatrice Bowman, Bureau of Medicine and Surgery, Department of the Navy, Washington, D. C.

U. S. Public Health Service Nurse Corps.—Superintendent, Lucy Minnigerode, Office of the Surgeon General, U. S. Public Health Service, Washington, D. C.

Nursing Service, U. S. Veterans' Bureau.—Superintendent, Mrs. Mary A. Hickey, Hospital Section, U. S. Veterans' Bureau, Washington, D. C.

Indian Bureau.—Supervisor of Nurses, Elinor D. Gregg, Office of the Medical Director, Bureau of Indian Affairs, Dept. of the Interior, Washington, D. C.

Department of Nursing Education, Teachers College, New York.—Director, Isabel M. Stewart, Teachers College, Columbia University.

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Arkansas.—Pres., [illegible] Vincent's [illegible], Little Rock. [illegible]

California.—[illegible]

Colorado.—Pres., [illegible] Denver. [illegible]

Connecticut.—[illegible]

Delaware.—[illegible]

District of Columbia.—[illegible] N.W., Washington.

Florida.—[illegible]

Georgia.—[illegible]

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Illinois.—Pres., [illegible] Irving Park Blvd., Chicago. [illegible], 509 [illegible] League Pres., [illegible] Wood, [illegible] Blvd., Chicago. [illegible] Michael Reese Hosp., Chicago. [illegible] of Registration, [illegible], State Capitol, Springfield.

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